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AIDS IN SAN FRANCISCO

STATUS REPORT AND PRELIMINARY PLAN FOR 1987-88

Presented to the San Francisco Health Commission

December 16, 1986

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I. EXECUTIVE SUMMARY

AIDS IN SAN FRANCISCO: STATUS REPORT AND PRELIMINARY PLAN FOR FISCAL YEAR 1987-88 is the preliminary step in establishing a plan and budget for AIDS programs and services for the new fiscal year. It will serve as a basis for discussions surrounding allocations of local, State and Federal funds for AIDS activities.

The document is comprised of eleven sections. It begins with a description of the purpose and scope of the work done, and the process undertaken in developing the report/plan. This is followed by a report of the number of cases of AIDS on record in San Francisco and the number anticipated by June 1988, and subsequently a discussion of demographic trends and their implications for prevention and health care services

The balance of the report/plan is organized around nine categories of programs and support services:

1. surveillance, epidemiology and related research;
2. concerns of people of color and women;
3. public education;
4. provider education;
5. clinical screening and acute medical care;
6. chronic care and related support services;
7. mental health services;
8. substance abuse services;

and 9. administrative support and coordination.

Most sections include a discussion of the nature of activities covered in the section, an identification of goals, a brief description of current service configurations, a summary of factors and constraints which have or will probably have a particular impact on services, reaffirmation of relevant departmental policy, and an indication of the general direction in which program development is expected to move. Since the categories around which the document is organized are not mutually exclusive, there are frequent references to other parts of the document.

It is hoped that readers will appreciate the comprehensiveness of San Francisco's response to AIDS as well as the complexity of the problems being addressed.

II. INTRODUCTION

The current epidemics of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection are the most serious health crises ever faced by the City and County of San Francisco. This document provides an overview of the current situation and identifies the general direction of program developed planned by the San Francisco Department of Public Health (DPH) for the short-term future. It reflects several needs:

1. The need for an overview of the problems associated with managing the epidemic that have emerged to date and what has been done to address these problems.

2. The need for broadly based community-oriented educational and prevention programs to limit the transmission of HIV.

3. The need to continuously assess. . .

   - how the epidemic is growing, what the impact of educational and prevention programs have been, and what the demand for services related to it will be;

   - what existing services will need to be expanded or modified and what new services will need to be developed;

   - how to distribute the financial burden of the epidemic reasonably among private and public (local, state, national) agencies to maintain and expand these services;

   - how to insure that planning and management related to the epidemic are well coordinated with governmental agencies and community organizations;

   - what progress has been made toward the development of a vaccine and what progress has been made toward the development of effective therapy both for symptomatic and asymptomatic HIV-infected patients;

   - the need for an understanding of the constraints on the long range planning of responses to the epidemic.

This document has been organized around services currently in place and funded entirely or in part by DPH. Services of other providers are noted but discussed in less detail. It contains descriptions of current services and identified unmet or emerging needs.

The recommendations contained in this report have been shaped by a variety of intramural and extramural committees, groups and reports. They include::

- DPH's Executive Committee and the DPH's AIDS Committee;
- Hearings conducted by the San Francisco Health Commission;
- Reports on AIDS from the National Academy of Sciences and the Surgeon General of the United States Public Health Service;
- Recently enacted state and federal legislation regarding support for AIDS services;
- Observations about established and anticipated patterns of contracting with state and federal agencies;
- Written descriptions of current AIDS services from San Francisco service providers;
- Written descriptions of reported gaps in AIDS services and written proposals for expanded and new AIDS services from current service providers, advocacy groups, and community-based organizations;
- The Mayor's AIDS Task Force
- The Director of Health's Medical Advisory Committee on AIDS, AIDS Advisory Committee, and Minority Advisory Task Force on AIDS

The AIDS status report and plan should be viewed as a flexible working document which will change as the character of the epidemic changes. It should also be viewed as a reference document which can be used for planning the variety of services needed to deal with the epidemic. Finally, it should help place current and planned services in the context of managing the epidemic as a whole.

The report in its present draft does not include discussion of specific dollar amounts needed or sources from which they are likely to come. The information currently available on the probable costs of expanding services is not yet well developed. Likewise, information about probable funding from State and Federal agencies is not well refined at this point. We know, for example, that there will be new Federal funding for AIDS education in schools, service demonstration projects, and substance abuse services. It is not clear, however, how or under what conditions these funds are to be allocated to local jurisdictions.

The written descriptions of current AIDS services from San Francisco providers, from which most of the "current services" material is gleaned, are being edited for uniformity of format and to fill gaps in the information provided. A similar process is being conducted with the written descriptions of perceived AIDS service gaps and proposals for expanded and new services. These submissions will continue to influence the planning of services as it becomes more specific. When the editing is completed, they will be bound and available to the Health Commission for reference.

III. DIMENSIONS OF THE EPIDEMIC IN SAN FRANCISCO

A. CURRENT EPIDEMIOLOGY OF AIDS AND AIDS-RELATED COMPLEX

1. AIDS

By November 30, 1986, 2654 cases of AIDS and 1,477 deaths from AIDS had been reported to the Department of Public Health. This corresponded to an incidence of 390.9 cases per 100,000 population. The number of cases of AIDS diagnosed per month in San Francisco is continuing to rise (Figure 1).

The demographics of AIDS in San Francisco are shown in Tables 1-4. These include:

- 2,234 (84.2%) homosexual and bisexual men, 338 (12.7%) homosexual and bisexual men with histories of intravenous drug use, and 30 (1.1%) heterosexual intravenous drug users

- 2,626 (98.9%) adult and adolescent men, 22 (0.8%) adult and adolescent women, and 6 (0.2%) children

- 1,333 (50.2%) 30 to 39 years old, 675 (25.4%) 40 to 49 years old, and 378 (14.2%) 20 to 29 years old

- 2,291 (86.3%) whites, 177 (6.7%) Latinos, 150 (5.7%) Blacks, and 34 (1.3%) Asians and Pacific Islanders.

The proportion of gay and bisexual men with AIDS was lower among nonwhites [319/363 (87.9%)] than among whites [2253/2291 (98.3%), Table 5].

2. Other HIV-related diseases

Using estimates of the ratio between AIDS and ARC patients in cohort studies, we can estimate a range of the number of ARC cases in San Francisco:

- 4,246 to 22,824 total ARC cases (including lymphadenopathy syndrome)

- 2,389 to 19,908 cases of lymphadenopathy syndrome

The ratio of 8.6 cases of ARC per case of AIDS are from a cohort study conducted in 1984, and the ratio of 1.6 cases of ARC per case of AIDS are from a subset of the same cohort infected for an average of 70 months examined in 1986. The proportion of ARC to AIDS cases appears to decrease with increasing length of infection. The true number of ARC cases currently is, because of the relatively short duration of HIV infection among gay men in San Francisco, probably closer to the higher estimate than the lower.

3. Numbers of HIV-infected patients using inpatient health care facilities

Approximately 7-10% of all living AIDS patients are hospitalized in acute-care facilities and up to 10% are probably in need of subacute, intermediate, or chronic care services at any given point in time. Additionally, there is about one ARC patient hospitalized for every 10 hospitalized AIDS patient in both acute and chronic care settings.

4. Numbers using publicly subsidized health care services

Between January 1985 and June 1986, 32% of all AIDS hospitalizations in San Francisco were at San Francisco General Hospital (Table 6). During this same period 37% of all AIDS hospitalizations in San Francisco were reimbursed by public third party payors (MediCal, Medicare, etc.).

- Of 435 public-third-party-reimbursed hospitalizations, 278 (64%) were at San Francisco General Hospital

- Of the 70 self-pay hospitalizations, 48 (69%) were at San Francisco General Hospital

B. PROJECTED EPIDEMIOLOGY OF AIDS IN SAN FRANCISCO

1. AIDS

Using mathematical modelling to project total AIDS cases, total living AIDS cases, AIDS cases by race, and AIDS cases by major transmission categories (homosexual and bisexual men, homosexual and bisexual men with histories of intravenous drug use, and heterosexual intravenous drug users), we predict:

By June 30, 1987, there will be:

- 3,297 cumulative AIDS cases (Table 7)

- 1,226 living AIDS cases

- 2,780 (84.3%) cases among homosexual and bisexual men, 411 (12.5%) cases among homosexual and bisexual men with histories of intravenous drug use, and 41 (1.2%) cases among heterosexual intravenous drug users (Table 8)

- 2,822 (85.6%) cases among whites, 207 (6.3%) cases among Blacks, 219 (6.6%) cases among Latinos, and 46 (1.4%) cases among Asians (Table 9).

By June 30, 1988, there will be

- 4,485 cumulative AIDS cases (Table 7).

- 1,449 living AIDS cases

- 3,781 (84.3%) cases among homosexual and bisexual men, 560 (12.5%) cases among homosexual and bisexual men with histories of intravenous drug use, and 54 (1.2%) cases among heterosexual intravenous drug users (Table 8)

- 3,826 (85.3%) cases among whites, 291 (6.5%) among Blacks, 296 (6.6%) among Latinos, and 67 (1.5%) cases among Asians (Table 9).

Significant changes in the length of survival of AIDS patients (for instance, from antiviral therapy) will increase the number of living AIDS patients.

2. Other HIV-related diseases

Using the same ratios between AIDS and ARC patients as above, we can estimate a range of the number of ARC cases in San Francisco to be:

- 5,143 to 25,354 total ARC cases with 2,963 to 24,728 cases of lymphadenopathy syndrome by June 30, 1987

- 7,176 to 38,571 total ARC cases with 4,037 to 33,638 cases of lymphadenopathy syndrome by June 30, 1988.

As these patients will likely have been infected longer than ARC patients in 1986 (i.e., there will be relatively few new cases of HIV infection) the true number of ARC cases will be more likely be closer to the lower estimate than the higher.

3. Projected numbers of HIV-infected patients using inpatient facilities and publicly subsidized health care services.

Needs for hospitalization may increase as effective antiviral therapy becomes available leading to a higher percentage of living AIDS patients hospitalized because of more aggressive management of the disease and treatment of drug side effects. Additionally, as AIDS becomes more prevalent among intravenous drug users, there will be increased utilization of public-third-party reimbursement, potentially placing further demands on San Francisco General Hospital.

C. EPIDEMIOLOGY OF HIV INFECTION

1. Seroprevalence

Studies of cohorts of homosexual and bisexual men in San Francisco have found the prevalence of HIV infection to be between 33% and 73%. In a large population-based study conducted in the Castro district, the current prevalence is 52%. Studies of methadone clinic patients in San Francisco found that the prevalence of infection was 10% in 1985. More recent estimates suggest this prevalence may have doubled in 1986. Population-based data are not available for other populations in San Francisco, such as heterosexuals with multiple partners, blood transfusion recipients, and haemophiliacs.

Prevalence data from anonymous test sites are not population-based and do not accurately reflect the true prevalence of HIV infection either in the general population or in at risk groups. The prevalence of HIV infection among blood donors in San Francisco is currently 0.05% with the prevalence among male donors 0.06% and the prevalence among female donors 0.04%. These data are also from a non-random population but have some utility as a reflection of the overall seroprevalence of HIV infection in the general population. Other data on the seroprevalence of HIV infection in San Francisco are available from military recruit HIV screening programs. During the first three quarters of the screening programs, the seroprevalence among recruits from San Francisco was:

- Overall, 0.75%.
- 0.76% for men and 0.60% for women.
- 1.67% for whites, 0.60% for Blacks, 0% for Latinos, 0% for Asians and Pacific Islanders, and 0% for American Indians.

2. Seroconversion (Incidence)

Data from the homosexual and bisexual male cohorts suggest recent seroconversion rates of between 3% and 5% of uninfected men per year. No data are available for other at risk groups or the general population.

Further population-based cross-sectional and cohort studies will be needed to ascertain more fully the true seroprevalence and incidence of HIV infection in the general population and selected at risk groups.

FIGURE 1

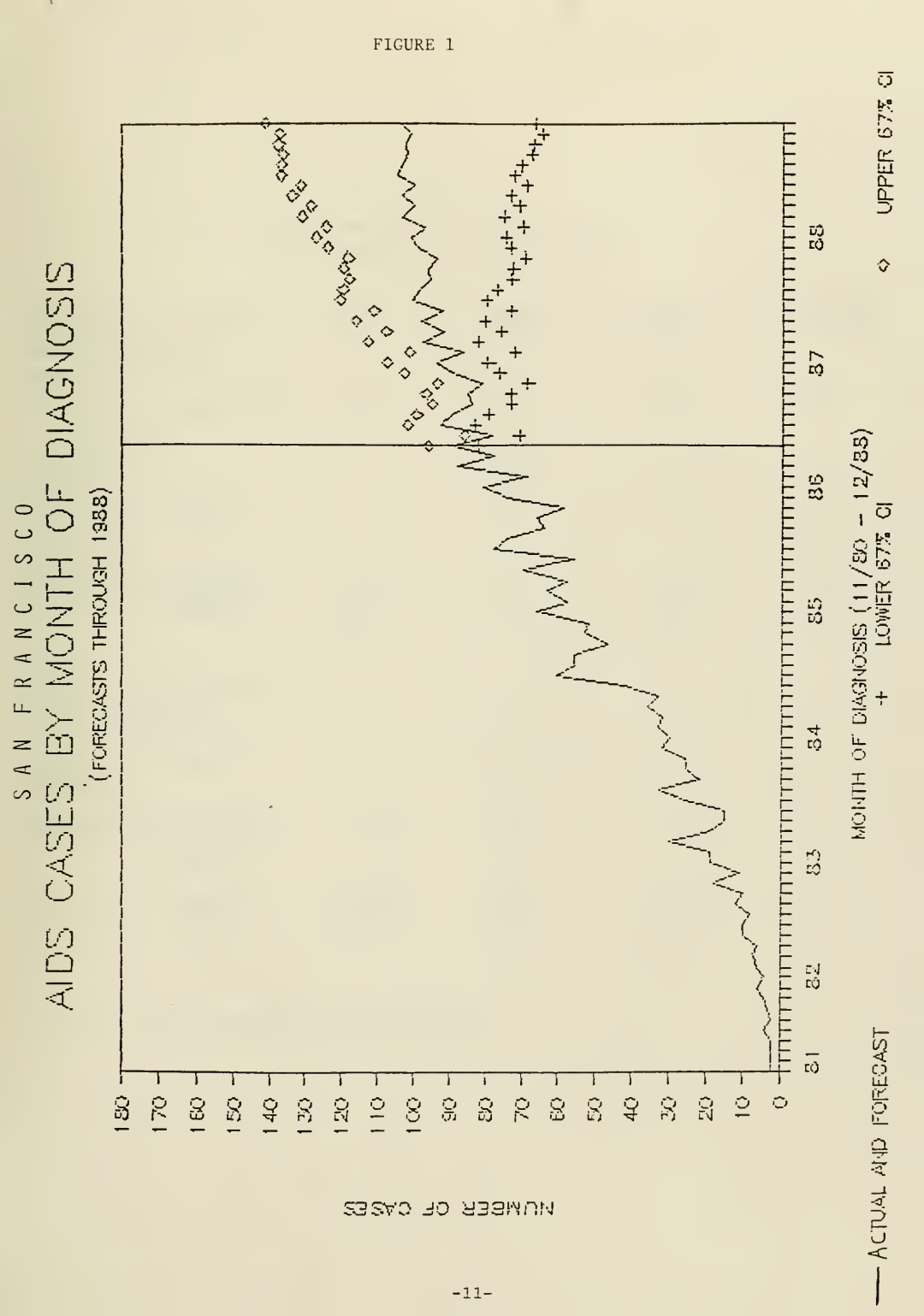
SAN FRANCISCO
AIDS CASES BY MONTH OF DIAGNOSIS
(FORECASTS THROUGH 1988)
NUMBER OF CASES
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
81
82
83
84
85
86
87
88
MONTH OF DIAGNOSIS (11/80 - 12/88)
— ACTUAL AND FORECAST
+ LOWER 67% CI
◇ UPPER 67% CI

TABLE 1

AIDS Cases by Transmission Category and Sex
San Francisco, 1981-1986*

TRANSMISSION CATEGORY	MALE	FEMALE	TOTAL	PERCENT OF TOTAL
ADULTS/ADOLESCENTS				
HOMOSEXUAL/BISEXUAL MALE	2,234	0	2,234	84.2
HOMOSEXUAL/BISEXUAL MALE AND IVDU	338	0	338	12.7
IV DRUG USER	21	9	30	1.1
TRANSFUSION RECIPIENT	13	6	19	0.7
HETEROSEXUAL CONTACT	4	5	9	0.3
HEMOPHILIA	3	0	3	0.1
NONE OF THE ABOVE/OTHER	13	2	15	0.6
SUBTOTAL:	2,626	22	2,648	99.7
CHILDREN (0-12 yrs.)				
CHILD OF HIGH-RISK/ AIDS PARENT	1	3	4	0.2
TRANSFUSION RECIPIENT	2	0	2	0.1
HEMOPHILIA	0	0	0	0.0
NONE OF THE ABOVE/OTHER	0	0	0	0.0
SUBTOTAL:	3	3	6	0.3
TOTAL	2,629	25	2,654	100.0

* Cases reported through November 30, 1986.

TABLE 2

AIDS CASES BY TRANSMISSION CATEGORY AND YEAR OF DIAGNOSIS

SAN FRANCISCO, 1981-1986*

YEAR OF DIAGNOSIS

Transmission Category	1981		1982		1983		1984		1985		1986*	
ADULTS/ADOLESCENTS	N	%	N	%	N	%	N	%	N	%	N	%
HOMOSEXUAL/BISEXUAL MALE	23	85.2	97	95.0	240	85.0	443	83.0	673	84.4	758	83.0
HOMOSEXUAL/BISEXUAL MALE AND IVDU	2	7.4	3	3.0	36	12.8	82	15.4	97	12.2	118	12.9
IV DRUG USER	0	0.0	0	0.0	2	0.7	4	0.8	8	1.0	16	1.8
TRANSFUSION RECIPIENT	0	0.0	0	0.0	0	0.0	0	0.0	11	1.4	8	0.9
HETEROSEXUAL CONTACT	0	0.0	0	0.0	1	0.4	2	0.4	0	0.0	6	0.7
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0	2	0.3	1	0.1
NONE OF THE ABOVE/OTHER	1	3.7	0	0.0	2	0.7	2	0.4	5	0.6	5	0.5
CHILDREN (0-12 yrs.)												
CHILD OF HIGH-RISK/ AIDS PARENT	1	3.7	2	2.0	0	0.0	0	0.0	0	0.0	1	0.1
TRANSFUSION RECIPIENT	0	0.0	0	0.0	1	0.4	0	0.0	1	0.1	0	0.0
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	27		102		282		533		797		913	

*Cases reported through November 30, 1986.

TABLE 3
AIDS Cases by Age Group
San Francisco, 1981-1986*

AGE GROUP	CASES	PERCENT OF TOTAL
0 - 4	6	0.2
5 - 12	0	0.0
13 - 19	5	0.2
20 - 29	378	14.2
30 - 39	1,333	50.2
40 - 49	675	25.4
50 - 59	210	7.9
60+	47	1.8
Total	2,654	100.0

*Cases reported through November 30, 1986.

TABLE 4

AIDS Cases by Race and Ethnic Group

San Francisco, 1981-1986*

RACE/ETHNICITY	CASES	PERCENT OF TOTAL
WHITE	2,291	86.3
BLACK	150	5.7
HISPANIC	177	6.7
ASIAN/PACIFIC ISLANDER	34	1.3
OTHER	2	0.1
TOTAL	2,654	100.0

* Cases reported through November 30, 1986.

TABLE 5

AIDS CASES BY RACE AND ETHNIC GROUP AND TRANSMISSION CATEGORY

SAN FRANCISCO, 1981-1986*

Transmission Category	Race/Ethnic Group									
	WHITE		BLACK		HISPANIC		ASIAN/ PACIFIC ISLANDER		OTHER	
ADULTS/ADOLESCENTS	N	%	N	%	N	%	N	%	N	%
HOMOSEXUAL/BISEXUAL MALE	1947	85.0	99	66.0	158	89.3	28	82.4	2	100.0
HOMOSEXUAL/BISEXUAL MALE AND IVDU	306	13.4	22	14.7	9	5.1	1	2.9	0	0.0
IV DRUG USER	11	0.5	13	8.7	4	2.2	2	5.9	0	0.0
TRANSFUSION RECIPIENT	14	0.6	2	1.3	1	0.6	2	5.9	0	0.0
HETEROSEXUAL CONTACT	4	0.2	4	2.7	1	0.6	0	0.0	0	0.0
HEMOPHILIA	2	0.1	0	0.0	1	0.6	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	5	0.2	7	4.7	2	1.1	1	2.9	0	0.0
CHILDREN (0-12 yrs.)										
CHILD OF HIGH-RISK/ AIDS PARENT	0	0.0	3	2.0	1	0.6	0	0.0	0	0.0
TRANSFUSION RECIPIENT	2	0.1	0	0.0	0	0.0	0	0.0	0	0.0
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	2291		150		177		34		2	

*Cases reported through November 30, 1986.

TABLE 6

AIDS PATIENT DISCHARGES BY ANTICIPATED PRINCIPAL PAY SOURCE AND TYPE OF HOSPITAL, SAN FRANCISCO, 1985 - JUNE, 1986

	Private Third Party				Public Third Party						Self-Pay		Total	
	Insurance		Other (HMO,PPO)		Medi-Cal		Medicare		Other					
HOSPITAL	N	(%)*	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
SFGH	53	(14)	2	(1)	256	(67)	8	(2)	14	(4)	48	(13)	381	(100)
KAISER, SF	0	(0)	155	(100)	0	(0)	0	(0)	0	(0)	0	(0)	155	(100)
ALL OTHER	350	(54)	122	(19)	119	(18)	29	(4)	9	(1)	22	(3)	651	(100)
TOTAL	403	(34)	279	(24)	375	(32)	37	(3)	23	(2)	70	(6)	1187	(100)

Source: West Bay Hospital Conference

*Percentage of row total

TABLE 7

SAN FRANCISCO AIDS PROJECTIONS BY FISCAL YEAR

FISCAL YEAR ENDING:	Cumulative No. of Cases (95% C.I.)	Cumulative No. of DEATHS (95% C.I.)	Number Alive (95% C.I.)	Percentage Alive (%)
June 1986	2230	1234	996	44.7
June 1987	3297 (2932-3660)	2071 (1891-2188)	1226 (1041-1472)	37.2
June 1988	4485 (3492-5475)	3036 (2577-3467)	1449 (915-2008)	32.3

TABLE 8

PROJECTED AIDS CASES BY TRANSMISSION CATEGORY & VITAL STATUS,

SAN FRANCISCO, 1987-1988*

Transmission Category	1987*				1988#			
	CUMULATIVE CASES		NUMBER ALIVE		CUMULATIVE CASES		NUMBER ALIVE	
ADULTS/ADOLESCENTS	N	%	N	%	N	%	N	%
HOMOSEXUAL/BISEXUAL MALE	2780	84.3	1034	84.3	3781	84.3	1222	84.3
HOMOSEXUAL/BISEXUAL MALE AND IVDU	411	12.5	153	12.5	560	12.5	181	12.5
IV DRUG USER	41	1.2	15	1.2	54	1.2	17	1.2
TRANSFUSION RECIPIENT	23	0.7	9	0.7	31	0.7	10	0.7
HETEROSEXUAL CONTACT	10	0.3	4	0.3	13	0.3	4	0.3
HEMOPHILIA	3	0.1	1	0.1	5	0.1	1	0.1
NONE OF THE ABOVE/OTHER	20	0.6	7	0.6	27	0.6	9	0.6
CHILDREN (0-12 yrs.)								
CHILD OF HIGH-RISK/ AIDS PARENT	6	0.2	2	0.2	9	0.2	3	0.2
TRANSFUSION RECIPIENT	3	0.1	1	0.1	5	0.1	2	0.1
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	3297		1226		4485		1449	

*Diagnosed as of June 30, 1987.
#Diagnosed as of June 30, 1988.

TABLE 9

PROJECTED AIDS CASES BY RACE/ETHNIC GROUP AND VITAL STATUS,
SAN FRANCISCO, 1987 - 1988

RACE/ETHNIC GROUP	1987* Cumulative Cases N	1987* Cumulative Cases %	1987* Number Alive N	1987* Number Alive %	1988# Cumulative Cases N	1988# Cumulative Cases %	1988# Number Alive N	1988# Number Alive %
WHITE	2822	85.6	1050	85.6	3826	85.3	1236	85.3
BLACK	207	6.3	77	6.3	291	6.5	94	6.5
HISPANIC	219	6.6	81	6.6	296	6.6	96	6.6
ASIAN/PACIFIC ISLANDER	46	1.4	17	1.4	67	1.5	22	1.5
OTHER	3	0.1	1	0.1	5	0.1	1	0.1
TOTAL	3297		1226		4485		1449	

* Diagnosed as of June 30,1987.
\# Diagnosed as of June 30,1988.

IV. SURVEILLANCE, EPIDEMIOLOGY, AND RELATED RESEARCH

A. GOALS

The overall purpose of these activities is to help us understand better how HIV infection manifests itself, how it is transmitted, where it is moving in our community and how fast, and what kinds of education and interventions are likely to be or have been successful in curtailing its movement. These activities focus on the collection of numerical data and the analysis of significant patterns evident in the numbers.

The surveillance data set is used extensively for predicting future numbers of cases, AIDS-associated morbidity and mortality, and the changing nature of the epidemic.

San Francisco provides a unique setting for such activities. In one relatively compact geographic area, there is a high concentration of cases, a community commitment to an aggressive education and prevention support program, and a large pool of talented and experienced researchers to draw on.

B. ACTIVITIES

In California, clinical AIDS as defined by the US Public Health Service's Centers for Disease Control (CDC) is a reportable disease. San Francisco has an "active" surveillance program, which works closely with private and public providers of medical care to insure that data critical to our understanding of the nature and dimensions of the epidemic are captured without compromising the confidentiality of patients.

Tracking patterns of seroconversion and manifestations of HIV infection that do not meet the criteria established in the "surveillance definition" of clinical AIDS is often accomplished through following carefully selected cohorts of volunteers who are representative of population groups known to be at risk for AIDS. Individuals who volunteer to be subjects in such studies are contacted, tested for HIV infection, and interviewed at regular intervals over long periods of time. Testing is often very important in such studies, since it provides hard data about transmission. Since AIDS is transmitted almost exclusively through sexual contact or needle sharing, interviews often focus on behavior, attempts to change behavior and the usefulness of education efforts. Those following each cohort provide education and counseling to subjects in addition to tracking their responses.

Tracking knowledge of AIDS, its transmission, and the impact of prevention education efforts is also undertaken in situations where no testing for HIV infection is done. A representative sample of a targeted population group is identified and interviewed to establish what the group targeted already knows about AIDS, how they have responded to what they know, what needs to be addressed next, and what further interventions would be appropriate. Interviews are conducted in person or by telephone. These kinds of population-based surveys are repeated from time to time to measure the nature and extent of responses by the group targeted to prevention education efforts.

Contact tracing and related individual education are feasible in situations where the trail of transmission is relatively clear and the number of contacts small.

Surrogate markers of behavior patterns provide useful information as well. Where a sexually transmitted virus such as HIV is concerned, for example, data confirming a reduction in the incidence of rectal gonorrhoea among men can be taken as an indirect indicator of a reduction in unprotected anal intercourse among gay/bisexual men.

C. CURRENT ACTIVITIES OF DPH

1. Case reporting of CDC-defined AIDS in San Francisco is managed by DPH's AIDS Office and depends almost entirely on Federal funding for its operations.

2. The AIDS Office (AO) conducts Federally-funded epidemiologic research projects in the areas of the natural history, biology and epidemiology of HIV infection in gay and bisexual men and of transmission-associated HIV infection. The AO also cooperates with research groups from the University of California and the Centers for Disease Control in studies of HIV transmission to female sexual partners of bisexual men, the psychosocial ramifications of HIV antibody testing, the transmission of HIV infection in households, and the epidemiology of AIDS in patients surviving more than three years.

3. Substance abuse treatment programs administered by DPH's Community Substance Abuse Services (CSAS) and mental health services cooperate with several concurrent research efforts being conducted under the aegis of the University of California San Francisco's SAMHA Center. The Substance Abuse and Mental Health in AIDS (SAMHA) Center, supported by a grant from the National Institute of Mental Health (NIMH) and the National Institute of Drug Abuse (NIDA), creates a working environment in which academic researchers at University of California - San Francisco and University of California - Berkeley, county health officials at DPH, and minority health professionals associated with Bayview/Hunter's Point Foundation can benefit from a pooling of knowledge, skills and community activities. The focus of the center is on developing and testing preventive interventions and on formulating and disseminating health policy guidelines.

4. Through its contract with the San Francisco AIDS Foundation, DPH has underwritten base-line and tracking surveys of gay/bisexual men and heterosexuals at risk for AIDS. In early 1987, DPH will contract with Black- and Latino-identified research teams to conduct a population based survey of their respective communities regarding knowledge of and attitudes toward AIDS and its prevention.

5. Contact tracing of heterosexual partners of persons with AIDS is conducted by DPH's Bureau of Communicable Disease Control (BCDC). In conjunction with Irwin Memorial Blood Bank, the Bureau also provides counseling, education and testing of recipients of HIV-infected blood.

6. Surrogate markers such as gonorrhoea, hepatitis, and syphilis rates are reported to and analyzed by the Bureau.

D. FACTORS INFLUENCING SURVEILLANCE, EPIDEMIOLOGIC STUDIES RELATED RESEARCH, AND EDUCATION ASSOCIATED WITH THEM

1. The usually long period between infection with HIV and the development of symptoms which can be traced to HIV infection has complicated the problem of tracking this disease.

2. The surveillance definition of AIDS only identifies very advanced clinical manifestations of HIV infection. This is the only manifestation of the disease that is reportable at this point. This hampers efforts to gauge the size and scope of the overall problem of HIV-associated disease.

3. Questions about insuring confidentiality emerged around AIDS making it necessary to limit use of the antibody test to situations in which subjects' identity can be particularly well protected.

4. Prospective studies (i. e. studies built around a representative cohort to be followed over a long period of time) are extremely expensive and traditionally have depended on Federal funding for support.

5. Population based surveys of risk group knowledge, attitudes and behavior among the particular groups at risk for AIDS (e. g. gay/bisexual men, IV drug users) are extremely useful in the development of effective educational programs. However, to date state and federal funding for such surveys has been limited.

E. POLICY REAFFIRMATION

1. DPH reaffirms its policy that antibody testing should be conducted only in a manner consistent with the provisions of AB403 and which maximizes the protection of information identifying any subject participating in the studies.

2. DPH reaffirms its commitment to careful behavioral and serologic assessments of populations targeted for education and prevention support programs to maximize the effectiveness of prevention and education programs.

F. PROPOSED ACTIVITIES

1. DPH should maintain its current level of funding for these activities.

2. Expand behavioral and serologic surveys among specific ay risk groups and the general population.

3. DPH should initiate sentinel-physician surveillance of AIDS related conditions to provide more accurate information about the prevalence of ARC and degree of disability among ARC cases.

3. DPH should articulate conditions under which the Department would be able to support making certain forms of AIDS-related conditions reportable. The goal would be to facilitate epidemiologic studies and to strengthen the foundation for making those with severe manifestations of ARC presumptively eligible for MediCal and disability benefits without compromising their rights or interests.

SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH

Goals	Program components	Factors influencing program development
Better understanding of HIV infection - How it manifests itself - How it is transmitted - Kinds of education successful in curtailing its transmission In conjunction with studies, educate subjects on preventing transmission and controlling the development of clinical disease	Active surveillance of cases which meet CDC criteria for clinical AIDS Research on natural history, biology and epidemiology of HIV infection Cooperation with research in substance abuse treatment programs Population-based knowledge and attitudinal surveys which assess community need for and response to AIDS prevention programs Contact tracing of heterosexual partners Following surrogate markers as indicators of particular behavior patterns	Long period between infection and development of symptoms Number of cases requiring active surveillance is growing Clinical definition of AIDS is limited Protection of human subjects participating in surveys and cohort studies is a complicated process and is critical to their success Cohort studies are expensive and have had to depend on limited Federal funding Knowledge/attitudinal surveys are difficult

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VI. CONCERNS OF PEOPLE OF COLOR AND WOMEN

A. GOALS:

Outside of San Francisco, there is a disproportionate number of AIDS cases among people of color. Although rates among people of color in San Francisco are lower, the numbers of reported cases have increased and serologic studies in San Francisco suggest that the rate of seroconversion in racial and ethnic minority communities, particularly among substance abusers, is rising. The picture of what has happened in other communities, most notably on the East Coast, is a stark reminder of what could happen here if adequate measures are not taken to prevent further spread of HIV within these communities. There is a need to expand and make more effective education and prevention programs that people of color in San Francisco can identify with and respond to.

The proportion of AIDS cases among women is also much higher outside of San Francisco, and the majority are women of color. Needle sharing by IV drug users plays a large role in the transmission of HIV to women outside of San Francisco: the majority are infected by sharing needles themselves or from sexual contact with an infected IV drug user. The chances of a pregnant women passing HIV infection on to her fetus are very high. Here too is a unique opportunity to avoid some dimensions of the East Coast's experience with AIDS. There is a need to insure effective education and prevention program that women can identify with and respond to.

Achieving DPH's general goal of providing high quality health care and other support services for people infected by HIV requires services which are responsive to the special concerns of women as well as culturally and linguistically appropriate for people of color.

B. BACKGROUND INFORMATION

The racial and ethnic breakdown of total cases has indicated a trend of increasing numbers of people of color being diagnosed with AIDS each year in San Francisco, although the overall distribution by race and ethnicity has remained relatively stable over the last three years and is expected to maintain this pattern over the next eighteen months. The table below reflects San Francisco data:

		1984	1985	1986
White	Total	472	676	736
	%	88.7	85.1	85.2
Black	Total	23	45	56
	%	4.3	5.7	6.5
Latino	Total	33	59	57
	%	6.2	7.4	6.6
Asian-Pacific Islander	Total	4	14	13
	%	0.8	1.3	1.5

There has been a 100% increase in the number of AIDS cases among nonwhites from 60 cases in 1984 to 126 cases in 1986. The estimated projections for racial and ethnic minorities in 1987 are 207 new cases among Blacks, 219 among Latinos and 46 among Asians and Pacific Islanders. This represents an almost eight-fold increase since 1984. In each community, the majority of new cases are expected to be gay and bisexual men: 80.7% of the new Black cases, 94.4% of the new Latino cases, and 85.3% of the new Asian and Pacific Islander cases.

The reported AIDS cases among women show a five-fold increase over the same period, although the raw numbers are too small to make this statistically significant. The following table indicates cases by gender:

		1984	1985	1986
Males	Total	530	787	852
	%	99.6	99.1	98.7
Females	Total	2	7	11
	%	0.4	0.9	1.3

These counts of reported cases should be kept in mind, but the important numbers are those which indicate seroconversion. Since clinical AIDS usually takes a very long time to manifest itself (often in excess of five years from the time of infection), one- and two-year projections for reported cases are not a particularly graphic indicator of the challenge presented to education and prevention programs. In the absence of extensive data about seroconversion in San Francisco outside of San Francisco's gay and bisexual male community, we need to look at national patterns for some indication of what could occur.

Nationally, the statistics are quite different from the above San Francisco data. The table below reflects figures provided by the US Public Health Service Centers for Disease Control at November 24, 1986:

Racial/Ethnic Group	Cases	Percent
White	16,807	60
Black	6,969	25
Latino	4,102	15
Other	291	1
Gender	**Cases**	**Percent**
Males	26,110	93
Females	2,059	7

From this table, it is clear that nationally there is a disproportionate number of people of color with AIDS: 38% of the AIDS population in the adult and adolescent group and 80% of the children with AIDS are from racial and ethnic minority communities. These disproportionate numbers have not been seen in San Francisco, as indicated in the first table. Therefore, San Francisco seems to have a unique opportunity to demonstrate that education and prevention programs, which are far less costly than treatment programs, can be effective in addressing the threat of AIDS among people of color.

Data on AIDS among women in San Francisco juxtaposed to the national figures shown above also supports the argument that we have an opportunity no longer available to many urban centers on the East Coast to prevent the spread of AIDS among women.

C. FACTORS INFLUENCING AIDS EDUCATION AND SERVICES TO PEOPLE OF COLOR AND WOMEN

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to these target populations. The key factor, however, is the fact that people of color and women have (a) come to appreciate the threat of AIDS and the fact that it can be avoided by behavior change and (b) perceived that the necessary education and prevention support services are not adequately in place to significantly reduce high risk behavior in their communities and service settings.

D. CURRENT SERVICES

Many of the programs described in the following pages provide services to people of color and women but do not routinely document these as distinct services. Services targeted to gay and bisexual men, for example, often include members of racial and ethnic minority groups. When information about race and ethnicity or sex is available, it is reflected in the description of current services in the following service areas: surveillance, epidemiology and related research; public education; provider education; clinical screening, primary care, and acute hospital care; chronic care and related support services; mental health and substance abuse services.

E. POLICY REAFFIRMATION:

1. DPH should ensure that prevention education programs and intervention strategies are developed in San Francsico which will meet the unique needs of people of color and women at risk for AIDS in a timely fashion.

2. The design and content of AIDS education and intervention efforts among people of color and women should be shaped by information from epidemiologic research as well as careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors.

3. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations who educate the general and at risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with people of color and women.

4. AIDS provider education must address directly attitudes that may distort the way in which information about AIDS is received by those participating in training. Of particular concern where AIDS is at issue are attitudes about homosexuality, racial and ethnic minority groups, women, people with substance abuse and mental health problems, and death and dying.

5. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture and language should be evident in all service settings.

6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are sensitive to people of color and women. Staffing patterns should reflect the populations targeted and served.

7. DPH should ensure that each AIDS service contractor includes in their annual program proposal a plan for addressing the special needs of people of color and women as they relate to the services concerned.

5. DPH should ensure that people of color and women participate in the Department's periodic monitoring of contract services.

VI. PUBLIC EDUCATION

A. GOALS

1. Goals of education to the general public

a. To educate the public about the transmission of AIDS and how they can protect themselves and others from infection.

b. To help the public understand the dimensions of the problem, its complexity, and the potential costs (in terms of lives, emotions, and dollars) so support for constructive and cost-effect services will be forthcoming

c. To demystify AIDS and in consequence reduce hysteria about casual transmission

2. Goals of education targeted to risk groups

In developing its AIDS prevention program, DPH has used as its basic reference a model articulated several years ago by San Francisco psychologist Steven Morin, PhD. The model is built on the premise that preventing the spread of AIDS requires that individuals infected and at risk of becoming infected must alter behaviors which are known to transmit the infection. In order for individuals to successfully manage new behaviors, Morin argues, the following beliefs need to be incorporated incrementally into individual belief systems. The issues are similar for people who are at risk and for those who have already been infected.

a. AIDS is a dreadful disease and I am at risk for it or may threaten others with it.

b. AIDS is avoidable. Certain actions will lessen the threat of my getting AIDS or giving it to someone else.

c. I can manage new, low-risk behaviors which will lessen the threat of my getting AIDS or transmit it, and I can still lead a satisfactory life.

d. I am willing and able to talk to potential sex partners or fellow needle users about low-risk behaviors which will lessen the threat of my getting or transmitting AIDS.

e. My peers and community will support these new behaviors.

San Francisco's AIDS prevention-through-education program has the goal of moving individuals at risk from (a) to (e) on the health beliefs scale. For convenience, this will be referred to as the Morin belief scale.

B. EDUCATIONAL VEHICLES

A wide variety of communication vehicles are used for general education as well as promoting behavior changes. Where general education ends and prevention support begins depends on the individual's perception of risk. The vehicles are listed here in an order which reflects increasing individual involvement and confrontation. The order also reflects degrees of exposure that would lead some to progress through the Morin belief scale.

1. Media advertising: Brief messages designed to reach large numbers of people. Advertisements are placed in general circulation newspapers and magazines and in specialized outlets (e. g. community newspapers). Transit ads, billboards, and TV and radio spots are also used.

2. News and feature coverage: Stories which enhance audiences' general awareness and understanding of the health concerns associated with the AIDS epidemic are promoted.

3. Pamphlets and collateral materials: These include all materials developed for distribution via mail and street intercepts, at public forums and health care facilities. Specific messages and target populations vary. Most are printed and can be carried away; some are video presentations.

4. Telephone information and referral services: An information clearinghouse to respond to questions stimulated by other elements of the prevention program and referrals for persons wishing to participate in other aspects of the program. The hallmarks are easy access to information, comprehensive and accurate information, and caller anonymity.

5. Forums, workshops and classes: One session group training events which reinforce the basic messages of other education efforts and include panel discussions, lectures, video presentations and opportunities for getting brief answers to questions. The specific subject matter and focus of these events varies depending on the audience. Some of these events are intiated by the provider; some are offered in response to requests from participant groups.

6. Individual health education and counseling: One-on-one and face-to-face discussion of issues related to AIDS prevention. The most obvious example of education at this level is the interaction that occurs when clients of the anonymous antibody testing program receive their test results. Since the testing in this setting is

not done in the context of a more general medical examination, it is valued more as an opportunity for education than clinical screening. The "line" between health education and mental health support (therapy) in such situations is not necessarily a distinct one, although it is sometimes convenient to discuss the distinction as a function of time and number of sessions.

7. Peer support groups: Group interactions whose principal agenda is to provide mutual support for behavioral change

8. Volunteer participation in AIDS organizations/services: Opportunities for self actualization in the fight against AIDS which go beyond opportunities to discuss personal concerns and behavioral changes.

C. TARGET POPULATIONS

General education is targeted at everyone, including groups at risk. Prevention education is targeted to groups at risk. Target populations are described in a variety of ways which do not result in mutually exclusive groups. They include:

1. The general public

2. Groups defined by behavior: men who have sex with other men, IV drug users/needle sharers, people whose sexual behavior is disinhibited by substance use, people with multiple sexual partners, sexual partners of the aforementioned groups, sexual partners of people infected through blood transfusion/blood products,.etc.

3. Groups defined by community: people whose primary "community" is defined by their race or ethnicity, gender, sexuality or sexual orientation, etc.

4. Groups defined by the place they are available to be educated: jail inmates, youth in school, patients of health care clinics, employees, members of a church, community group or social organization..

D. TARGET POPULATION ASSESSMENTS

San Francisco's AIDS education programs are, whenever possible, built on the foundation of quantitative and qualitative assessments of populations targeted. Quantitative assessments (population based surveys) help to determine where people are on the Morin's five-step belief scale discussed earlier, how they have responded to what they already know, and what communication vehicles they are likely to respond to. They may also also include seroprevalence and incidence studies of the target population. Qualitative assessments (usually using focus groups representative of target populations) help to shape quantitative surveys as well as determine the likely impact of draft materials and approaches to particular target populations.

E. MESSAGE CONTENT

DPH-associated educational programs follow the general principals that (1) all messages should be consistent with the latest developments in epidemiological and medical knowledge of AIDS and its transmission and (2) messages should be conveyed through mediums (print, pictures, oral/aural) and in language (visual, verbal) which the audience targeted will understand and respond to. Specific messages, however, will be varied. Important determinants of message content include:

1. Who is targeted: the "identity" of the audience targeted and the social and cultural value systems associated with that identity.

2. What they already know/believe: where the audience is on the Morin scale of incremental beliefs described above

3. Who is delivering the message: status in the community, relationship to audience, etc.

4. What resources are available: what is feasible given the setting and funding constraints; what are others doing

5. What literacy/education levels can be assumed: the level of education, literacy and language capability of the audience addressed

6. What medium(s) are used: print, pictures, oral/aural

7. What levels of formality the audience will respond to

F. FACTORS INFLUENCING DEMANDS FOR GENERAL AND PREVENTION EDUCATION PROGRAMS

1. The size and complexity of the epidemic and its impact on individuals, institutions and the public psyche are expanding dramatically. Even when general education efforts have worked reasonably well, the growing pressure of circumstances encourages demagoguery and hysteria. General education needs to be provided on an ongoing basis, even in a community such as San Francsico, where overall community response has been very responsive.

2. Advocacy groups have emerged representing communities and settings who (a) recognize the threat of AIDS and the fact that it can be avoided by behavior change and (b) perceive that the necessary education and prevention support services are not in place to make a significant dent in high risk behavior in their communities/settings. These groups primarily represent people of color and substance abuse service education and treatment settings.

3. Serologic studies of IV drug users in treatment programs indicate that seroconversion among IV drug users is growing and, by extension, that education and prevention support services to this population and its distinct subgroups have not yet shown an impact.

4. Population based serologic studies of self-identified gay/bisexual men in San Francisco indicate that 55% of the community has already been infected with HIV and the annual seroconversion rate is down to 4%. This reduction in seroconversion in community where the "pool" of infected individuals is already so large suggests that the overall prevention education effort in this community has had a positive impact.

   Other population-based surveys of knowledge and attitudes among gay and bisexual men also indicate that (a) the immigration to the community is high (an average of 8% per year over the past three years), (b) occasional "slippage" from safe sex practices is widespread, and (c) particular subgroups of the community (primarily those involved with substance abuse) have not responded at all to prevention education efforts.

   Data from DPH's sexually-transmitted diseases (STD) clinic indicates that (a) rectal gonorhea rates among men (evidence of sex without condoms among gay/bisexual men) have "leveled off" after a long-term pattern of fewer cases each month (suggesting that a core group has not been reached by existing programs),

5. A population based survey of multiple/high-risk partner heterosexual adults indicates that risk group members are very active sexually, aware of the AIDS epidemic, moderately informed about transmission, but have done little to accommodate behavior changes other than reduce somewhat (a) the number of partners they have and (b) their use of recreational drugs.

6. Population based surveys specifically targeted to San Francisco's Black and Latino communities will be initiated in early 1987. Data from these surveys should indicate where these communities are on the Morin "belief scale", their understanding of risk reduction, the extent of the adaptation of risk reduction behaviors, and the communication vehicles they have confidence in. These studies should help focus prevention education efforts in these communities.

   Data from DPH's STD clinic indicates that STD rates among adolescents and young adults, particularly those from racial/ethnic minority communities, are still high.

7. While the numbers of documented AIDS cases among Asians/Pacific Islanders in San Francisco remains small, the fact that 59% of these (20 out of 34) have been among gay/bisexual Filipino men will focus attention on this community as well.

8 . Federal (CDC) and State (DHS) funding offices are particularly anxious that educational materials be "inoffensive" to the community at large. Since sexual behavior and substance abuse information is a significant factor in AIDS education materials, it can be difficult to meet Federal and State requirements and still provide messages that will really reach groups targeted. CDC has dealt with the issue by requiring the appointment of a local panel to review CDC-funded materials. DHS policy calls for review of all materials by DHS staff in Sacramento and prohibits the use of "slang". (In one of the more interesting paradoxes of AIDS contracting, DHS has prohibited the distribution of "Can We Talk?" because it includes slang. This is a brochure which San Francisco's CDC-endorsed review panel singled out as one of the "best" they had seen precisely because it used terminology that the audience targeted was likely to respond to.)

G. CURRENT SERVICES

Since current service budgets are generally organized around cost centers defined by educational vehicle, the following discussion is organized around educational vehicles. Services whose principal target population is substance abusers and whose principal link to DPH is through CSAS are discussed in the section on Substance Abuse Services.

1. Media advertising

The San Francisco AIDS Foundation develops advertisements primarily for display on public transportation vehicles, on billboards and in community newspapers. Messages and placement vary and are generally coordinated with the themes being promoted in community forums and literature being distributed. Since most of the advertisements (no matter what the theme) are designed to encourage people ultimately to get more information, the impact of certain campaigns can be measured by the increase in calls to San Francisco's AIDS Hotline on the topic the campaign promotes awareness of (e. g. the risk of sharing needles, the risk to heterosexuals). The Foundation reports that over half of their media advertising budget in 1986-87 will be used for campaigns targeted to women, people of color or needle users.

2. News and feature coverage:

Both the Department of Public Health and the San Francisco AIDS Foundation employ liaisons to work with print and electronic media to promote accurate and constructive coverage of the AIDS epidemic in news stories as well as printed feature stories, panel discussions, talk shows and documentaries. The Foundation estimates that over 40% of media liaison work in 1986-87 will focus on issues related to women, people of color, heterosexual transmission and needle users.

3. Pamphlets and collateral materials:

The AIDS Foundation develops and distributes a wide variety of materials for different target populations in different settings. In some instances, a particular piece for a targeted population will stand on its own; in others it is part of a comprehensive package which may include a video, brochures, posters designed for a sustained and comprehensive educational effort in a particular setting (e. g. a large corporation). Materials are sometimes developed in collaboration with specific independent groups (e. g. Forensic Services AIDS Project, the Women's AIDS Network). Materials are available in Spanish, Chinese and Tagalog as well as English. They are distributed on request, at Foundation-sponsored forums and workshops, and through a network of distribution sites as well as street intercepts.

In FY 86-7, San Francisco's Instituto Familiar de la Raza and the Bayview Hunter's Point Foundation received funding directly from California DHS to provide AIDS education targeted to people of color. Some of this funding will be used for materials development and distribution.

4. Telephone Information and Referral:

The AIDS Foundation recruits, trains and supports volunteer counselors who operate the AIDS Hotline approximately 70 hours a week. It is a resource for people who are ill with AIDS/ARC as well as for those seeking information about AIDS risk, transmission, prevention and AIDS antibody testing. The service is anonymous, non-judgmental, and easily accessed. Spanish-speaking counselors are available during a limited number of shifts per week. Spanish and Cantonese recorded messages are available at all other times. Their equipment includes a TDD hookup for the deaf. The service currently accommodates approximately 32,000 calls a year.

All AIDS service organizations receive and handle calls for general information about AIDS and referral to AIDS services.

5. Forums, workshops and classes

a. The AIDS Foundation's Educational Events Program is a centralized resource which provides speakers and coordinates AIDS educational events for a wide variety of groups. Speakers provide easy-to-understand, specific, detailed information about AIDS to specialized groups ranging from San Francisco dentists to employees at the Levi Strauss Company. The program also provides informational booths at diverse community events such as the Martin Luther King Day Prade and the Japantown Fair. Programs are tailored to fit their audiences; some provide basic or more advanced medical information about AIDS, while others focus on issues of casual contagion, infection control, and the emotional issues which surround working with someone who has AIDS.

Program staff recruit, train and supervise volunteer speakers, many of whom are health care professionals, and coordinate the speaking requests received. Staff also produce educational events, where a need for such an event is determined by research surveys.

The program provides sign language interpretation upon request, and can provide speakers in a variety of languages. Special effort is made to integrate AIDS educational events into other occasions which draw audiences at high risk or with a specific need for AIDS information, such as neighborhood street fairs. During 86-7 290 events will be organized through this program.

The Foundation anticipates that well over half of their staff time in this program will focus on the concerns of racial and ethnic minorities, women and substance abuse.

b. DPH's Bureau of Family Health (BFH) is working in cooperation with the San Francisco Unified School District (SFUSD) to develop and implement a comprehensive AIDS education curriculum for San Francisco Schools. The curriculum will be piloted in several classes during 86-7 but the main focus this year will be the development, delivery and evaluation of a training program for middle and high school teachers, which is discussed at greater length under Provider Education.

c. In FY 86-7, San Francisco's Instituto Familiar de la Raza and the Bayview Hunter's Point Foundation received funding directly from California DHS to provide AIDS education targeted to people of color. Some of this funding will support forums and workshops.

d. The Women's AIDS Network (WAN) and the California Prostitutes Education Project (CAL-PEP) are two all-volunteer groups who also sponsor and provide speakers for forums and workshops on AIDS.

6. Individual health education and counseling:

San Francisco's program for anonymous HIV antibody testing were initially called "the alternate test site program" (alternatives to blood banks). They are now generally referred to as "anonymous test sites". This program is a comprehensive effort that brings together media advertising, pamphlets and collateral materials, small group education and individual health education and counseling. The focus, however, is on the opportunity for dialogue and counseling for which the test serves as a catalyst. Since the testing is not done in the context of a more general medical examination, it is valued more as an opportunity for education than clinical screening. The DPH policy to offer this testing without assembling personal identifying information on any participants is supported by State law. At current rates, approximately 10,500 individuals will be tested and counseled through this program in 86-7. Of those tested, approximately 11% are expected to be women and 15% people of color.

The basic safeguards of anonymous testing are: (a) no personal identifying information on program participants is sought or recorded; and (b) staff of the testing program have no job-related responsibilities which are likely to put them in contact with those tested outside the testing program. The purpose of (b) is to provide reasonable assurance that staff members will not be able to identify a person tested because of knowledge gleaned from job-related intereactions outside of the testing program itself.

DPH has contemplated offering antibody testing with a prevention education focus to clients of substance abuse and STD treatment programs at substance abuse and STD treatment settings. This program was to be different from anonymous testing to the extent that at least one staff member from the treatment program would, as the on-site educator/counselor for antibody testing, have personal knowledge of which clients were tested and what the results were. The proposal was based on the assumption that procedures could be developed which would adequately protect individuals participating in the program and the record of their test results. In the absence of a general concensus that sufficiently rigorous safeguards could be designed for such a program, the proposal has been tabled. Instead, substance abuse and STD treatment programs will provide some general education about antibody testing and refer those who are interested to an anonymous testing site. A similar scenario of individual education and referral to an anonymous testing site will be developed for women who are patients of family planning, pregnancy testing and prenatal clinics.

The University of California San Francisco (UCSF) AIDS Health Project and Pacific Mental Health Services (PMHS') Operation Concern also provide individual health education and counseling as part of assessing potential participants in the peer support groups described below. As was noted in Section IV, epidemiologic research projects provide participates with opportunities for education and counseling as well.

DPH's Forensics AIDS Project staff offer individual education and counseling to inmates, in addition to circulating materials, rotating posters and training jail staff about AIDS.

7. Peer support groups

The Stop AIDS Project is an interpersonal communications campaign which seeks to organize a community-at-risk (primarily self-identified gay and bisexual men) in San Francisco to achieve the goal of ending transmission of the AIDS virus. The major strategy of the campaign is to shift prevailing community norms about sexual behavior, to make "safe sex" and the social interactions which support safe sex the norm. The Project's main focus is not the individual, but the group. It is viewed as a movement for social change with major health-promotion goals.

Street intercepts, door-to-door canvassing, and outreach to strategically placed opinion leaders are used to attract participants to volunteer-facilitated small group meets of 10-15 per single session group. Participants are encouraged and empowered to communicate with their sex partners and friends about the campaign to end transmission of the AIDS virus. Stop AIDS meetings are held nearly every day of the week, including weekends, in the homes of volunteer hosts throughout the City.

The single-session group efforts of the Stop AIDS Project, as presently constituted, have been scheduled since July 1986 to "wind down" by June 1987. The program was designed to provide a particular kind of educational "push" at a specific point in the history of the gay community's response to the epidemic. The designers of the program and DPH staff agree that the need for such a program will have been largely met by June 1987. By that date, approximately 8,000 San Franciscans will have participated in a Stop AIDS group, 3,500 in 86-7 alone. In light of experience to date, approximately 20% will have been from people of color. Three percent will have been women.

The UCSF/AIDS Health Project and PMHS/Operation Concern work together in providing one-time individual health consultations and closed, eight-week group support services. The target population for the services are people who are apprehensive about their prospects of acquiring AIDS and want to identify and find support for new behaviors likely to reduce their risk. Additionally, the project offers both drop-in and closed groups specifically for people with ARC in an attempt to help these individuals deal with their illness and reduce behaviors that may put others or themselves at greater risk. The majority of clients served in this program to date have been gay-identified males; 15% of clients served have been from racial and ethnic minority communities. Groups for special populations (e.g. people of color and women) are also organized: two groups exclusively for people of color have been conducted to date; women who have felt at risk have been seen predominantly for health consultations only. Taken together 3,500 San Franciscans are expected to participate in individual assessments and group sessions in 86-7.

The all-volunteer California Prostitutes Education Project (CAL-PEP) offers a monthly support group for prostitutes and other sex workers with an AIDS prevention focus.

8. Volunteer participation in AIDS organizations/services:

To varying degrees, all of DPH's AIDS service contractors provide opportunities for meaningful volunteer participation. There are, in addition, a number of community organizations who depend entirely on volunteers (e. g. WAN and CAL-PEP).

H. POLICY REAFFIRMATION

1. The focal point of coordination of AIDS education (both public education and prevention support) in San Francisco should be the San Francisco Department of Public Health.

2. The design and content of AIDS education and intervention efforts should be based on epidemiologic research as well as careful assessments of targeted audiences' understanding about AIDS and its transmission and of the obstacles which prevent adoption or maintainence of new behaviors.

3. Educational materials should utilize language and visuals which the audience(s) targeted are most likely to understand and respond to. Judgments about the propriety of materials produced and distributed with public funds should be made by local public health authorities and should be based on careful assessments of the needs of local audiences.

4. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations whose goal is to educate the general and at risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with groups not yet well addressed by established programs (i. e. programs targeted to hard-to-reach gay men, substance abusers, people of color, youth, and heterosexuals with multiple or at risk partners).

5. Anonymous antibody testing should be available to anyone fourteen years of age or older in the community who wishes to know his/her antibody status and is willing to participate in a pre- and post-test education and counseling program.

6. Confidential antibody testing should be promoted as a health education tool only if and when there is substantial community sentiment that procedures have been developed which adequately protect individuals participating in the program and the record of their test results.

I. PROPOSED SERVICES

[NOTE: Prevention support that specifically relates to substance abusers and treatment settings is discussed in Section XI.]

1. DPH should continue support of public education through media liaison which promotes broad and frequent coverage of AIDS issues in news and feature stories and through broad-impact efforts such as AIDS education in the workplace.

2. DHP should continue support of prevention education among gay/bisexual men sufficient to insure that the momentum towards new norms of safe sexual expression in the community is maintained.

3. DPH should augment AIDS education in DPH-managed settings, and expand existing contracts or add to the number of contracts with community based organizations who have the interest in and capability of managing such a program and who provide efficient access to targeted communities. Specific augmentations should be provided for :

   a. General education and prevention education targeted to people of color.

   b. General education and prevention education targeted to heterosexuals with multiple partners and single partners who come from the "classic" risk groups (gay/bisexual men, IV drug users, and hemophiliacs).

   c. AIDS education to youth in schools.

   d. Education in jails.

PUBLIC EDUCATION

Goals	Vehicles	Populations targeted	Factors influencing program development
General education: -To move those at risk to risk reductionia -To demystify AIDS and reduce hysteria -To help public understand dimensions and dynamics of the epidemic Risk reduction support: -To move those at risk along Morin scale and promote behavior change necessary to prevent HIV transmission	Media advertising News and feature stories Pamphlets and collateral materials Telephone I&R services Forums/workshops/ classes Individual health education and counseling Peer support groups Volunteer participation	General public Populations defined by behavior: - Men who have sex with other men - IV drug users/ needle sharers - People whose sexual activity is disinhibited by substance use - People with multiple sexual partners - Sexual partners of all the behavior groups - Sexual partners of hemophiliacs and other recipients of infected blood or blood products Populations identified by community: - Race/ethnicity - Gender - Sexuality/sexual orientation Populations identified by place: - Jail - School - Workplace - Clinic/treatment setting - Community group	General pressure of a growing and complex epidemic Emergence of special interest groups Patterns of seroconversion among risk groups Responses to community surveys Patterns evident in surrogate markers of risk behavior Necessary redundancy between programs for different target populations Politically motivated restrictions on language/ messages used in educational programs

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VII. PROVIDER EDUCATION

A. GOALS

The programs which DPH includes under the general heading of "Provider Education" serve two kinds of providers: (1) those who routinely provide services to people who are sick or concerned about their health (health care professionals and hospital workers, mental health and substance abuse treatment professionals, emergency service workers, etc.) and (2) those who, because of their work, are uniquely placed to educate others about the problem, reduce hysteria and promote risk reduction (teachers, detention facility staff, etc.)

In the case of those who routinely provide services to people who are sick or concerned about their health, the goal of provider education is to help them understand and respond appropriately around issues of symptoms and treatment, transmission and infection control, patient/client rights, psychosocial pressures generated by the epidemic, risk reduction, and the availability of related support services. In the case of those in a position to serve as an educational vector, the issues are similar but the emphasis is more on risk reduction and the special psychosocial dynamics of the epidemic than on the technical aspects of transmission, symptoms and treatment.

Provider education is particularly complicated when AIDS is at issue because service providers sometimes bring bias to such training. The vast majority of those in San Francisco who have been infected with HIV and have developed AIDS are members of behavioral minorities (gay men and IV drug users) whose behavior is, in the minds of many, considered reprehensible: people with AIDS/ARC and those at risk are frequently "blamed" for their circumstances. Insensitivity to the special concerns of racial and ethnic minority groups is often part of the bias as well. Provider education, therefore, must address these prejudices along with issues that are specific to HIV infection.

B. FACTORS INFLUENCING SERVICE CONFIGURATIONS

1. As AIDS cases become more numerous and health care for AIDS becomes more decentralized, the number of professionals whose jobs involve them with the epidemic will expand.

2. Staff turnover must be anticipated in training programs

3. New trends in opportunistic infections associated with HIV infection, new drugs, new treatment regimens, greater experience in the development and management of psychosocial support services, new tactics of the peddlers of AIDS hysteria, the pressure of dealing with an expanding epidemic --- any one or any combination of these may require new or expanded training efforts .

C. CURRENT ACTIVITIES

1. General

Professional associations and university-based training programs are expanding their role in educating their constituencies about AIDS. There are, in addition, periodic regional, national, and international conferences organized to inform and educate professional service providers about AIDS. Interest in AIDS is also increasingly reflected in professional journals and newsletters. San Francisco-based providers are frequently high-profile participants in these forums.

In San Francisco, an annual "AIDS/ARC Update" is co-sponsored by an array of local service providers and constitutes the most general effort to provide new information and renewed support to San Franciscans working on AIDS-related issues.

2. Training for medical professionals and other health care workers

San Francisco General Hospital's AIDS Outpatient Clinic (SFGH/Ward 86) offers clinicians a variety of opportunities to benefit from the expertise being developed at Ward 86 regarding the diagnosis, treatment and support of AIDS and ARC patients. In addition, physicians based at SFGH/Ward 86, in cooperation with UCSF, the San Francisco Medical Society and members of Bay Area Physicians for Human Rights, sponsor a monthly meeting of the San Francisco Community Physicians Consortium. At this meeting, physicians in private practice from San Francisco and the surrounding counties who are providing clinical services to people with AIDS or ARC meeting to review interesting or problematic cases and to keep up to speed with respect to clinical drug trials. Patients of participating in the consortium have access, through their physicians, to clinical drug trials managed by SFGH.

The California Nurses Association (CNA), working in cooperation with the San Francisco AIDS Foundation and AIDS Project Los Angeles and with special assistance from DPH's AIDS Office, has developed and is piloting state-wide program to train 750 hospital- and agency-based trainers of hospital and home health agency staff; 70 of these will be from San Francisco.

DPH's AIDS Office supports with State grant funds a half-time health educator who develops and implements training programs for local health care workers, in cooperation with the San Francisco AIDS Foundation. The program is particularly concerned with occupational categories that tend to be unaddressed in established training and professional development programs: e. g. hospital orderlies, laundry and food service personnel; assistants and technicians in private clinics. The program is geared to changing levels of awareness, knowledge, and attitudinal sensitivity. 1200 health care personnel are targeted for FY 86-7.

San Francisco General Hospital and a number of private hospitals in San Francisco (e. g. Kaiser, Pacific-Presbyterian, Mount Zion, St. Mary's) have also developed AIDS-specific training programs for in-house staff members.

3. Training for mental health professionals

The UCSF AIDS Health Project has provided educational services to mental health professionals from its inception, taking the skills and experiences of the project staff and making them available to other mental health and social service providers at all levels of training and licensure. AHP also offers trainings about the psychosocial issues in AIDS to other health care providers. There are multiple and complex issues raised by this disease: most notably the need to discuss sexuality and sexual practices, issues of death and dying, the related issue of suicide and the ethical issues raised in the care and treatment of persons with a terminal illness. In 86-7 the project's Mental Health Training Coordinator will organize and conduct workshops, forums and smaller trainings for 8,000 professionals in San Francisco. She also maintains an active liaison with Community Mental Health Services and other mental health agencies in the Bay Area. PMHS' Operation Concern cooperates with the UCSF/AIDS Health Project in the training of mental health professionals.

The AIDS Health Project also publishes a monthly newsletter, FOCUS, which summarizes developments in the areas of epidemiological, medical and psychsocial research which may have implications for psychosocial support services related to the AIDS epidemic.

The National Institute of Mental Health has provided the UCSF Department of Psychiatry with a grant to introduce coverage of all areas of psychosocial concern about AIDS in both continuing education and professional training programs of the UCSF Schools of Medicine and Nursing. The project includes special components for concerns of people of color and community based continuing education. The UCSF AIDS Clinical Research Center has received a State grant to organize in 86-7 three regional conferences entitled "AIDS and Mental Health: Clinic, Social and Administrative Issues" and to publish reports of the proceedings.

The State-funded AIDS education program at Bayview/Hunters Point Foundation also offers training for mental health professionals on concerns specific to AIDS in people of color.

4. Training for substance abuse professionals

The AIDS and Substance Abuse Education Program (ASAP) of the UCSF AIDS Health Project provides consultation and training about the intimate and complex interaction between AIDS and substance abuse. ASAP assists substance abuse agencies in dealing with AIDS and AIDS agencies in dealing with substance abuse. Services include formal trainings on topics such as substance abuse assessment, counseling strategies for substance abuse

clients with AIDS concerns, and basic AIDS information. Consultation services center upon treatment planning for individual clients and programmatic or agency needs concerning substance abuse and AIDS training. All drug and alcoholism treatment programs in San Francisco have been contacted and have had inservice training or consultation for staff members. The particular needs of gay men and Latino clients who are substance abusers have been included in training and consultations. Some direct education to clients in substance abuse treatment settings is also provided. An estimated 4,900 service providers will receive training or consultation from this program in FY 86-7.

In conjunction with a State-funded demonstration project described in Section XI, DPH contracts with the Multicultural Prevention Resource Center (MPRC) through the Bayview/Hunter's Point Foundation to develop and implement training for Community Substance Abuse Services (CSAS) agencies that is specific to the concerns of their Black, Latino and Asian clients at risk for AIDS.

5. Training for emergency service personnel

At some point in the past few years, San Francisco's police department, fire department, sheriff's office, and emergency medical services have all offered information and education about AIDS to their line managers and staff. The San Francisco AIDS Foundation will organize seminars and workshops for emergency service personnel on request from the department or the labor association concerned.

The American Red Cross and the California Firefighter Foundation recently received a grant from the California Department of Health Services to develop a training program on AIDS education for public safety department trainers.

6. Training for jail staff

Education concerning AIDS risk and risk reduction is given to all staff working within the three county jails, Ward 7D (SFGH) and Youth Guidance Center by the CDC-funded Forensic Services AIDS Project. Training concerning effective ways of working with people with AIDS and ARC is offered for those providing medical, correctional and social services to inmates and youth. Approximately 500 staff are employed at these facilities.

7. Training for SFUSD teachers

DPH's Bureau of Family Health (BFH) is working in cooperation with the San Francisco Unified School District (SFUSD) to develop and implement a comprehensive AIDS education curriculum for San Francisco Schools. The curriculum will be piloted in several classes during 86-7, but the main thrust this year will be the development, delivery and evaluation of a training program for middle and high school teachers. Project staff have compiled a Teacher's Guide designed specifically for use in middle and

high schools. A total of 120 teachers will be trained as part of this pilot project. From this total, six teachers (three middle school and three high school) will be selected to pilot the curriculum in middle and high school classes in a monitored study.

C. POLICY REAFFIRMATION

1. DPH should encourage the development of comprehensive and constructive AIDS education components in a broad spectrum of (a) professional degree training programs, (b) university-affiliated continuing education and in-service training programs, (c) training opportunities organized by professional associations and labor organizations, and (d) in-house training offered by local service providers. Experienced providers based at DPH should cooperate by making their experience available to those who are planning and implementing such training.

2. DPH should assist as much as possible in training efforts that will ultimately enhance the capacity of private sector providers to accommodate needs generated by the AIDS epidemic.

3. DPH recognizes that, to be constructive, AIDS provider education must address directly prejudices that may distort the way in which information about AIDS is received by those participating in training. Of particular concern where AIDS is at issue are attitudes about homosexuality, racial and ethnic minority groups, women, people with substance abuse and mental health problems, and death and dying.

D. PROPOSED ACTIVITIES

1. DPH should maintain current levels of direct funding for well-conceived and well-managed training programs for service providers.

PROVIDER EDUCATION

Goals	Provider groups	Factors influencing program development
Training for providers to help them respond appropriately to issues around symptoms and treatment, transmission and infection control, patient/client rights, etc.	Generally those whose job responsibilities bring them in contact with the epidemic	Number of professionals whose jobs involve them with the epidemic is expanding
Training for educational vectors emphasizing similar issues but with more emphasis on risk reduction and the psychosocial dynamics of the epidemic	Medical professionals and other health care workers	Staff turnover
Training which helps providers come to terms with their own potentially biased attitudes about "at risk" patient/client groups	Mental health professionals	New developments in understanding and treatment
	Substance abuse service professionals	Professional associations assuming a large role in this education
	Emergency service personnel	State funding promoting state-wide and regional training
	Jail staff	
	School personnel	

VIII. CLINICAL SCREENING AND MEDICAL CARE

A. GOALS AND ACTIVITIES

A general goal of San Francisco's response to the AIDS epidemic is to provide care for patients in a manner which is medically appropriate, psycho-socially supportive and culturally sensitive, as well as cost-effective. This goal is not unique to AIDS. However, the rapid development and complex dynamics of the AIDS epidemic have presented the Department with problems whose solutions have required dramatic departures from patterns of service delivery considered typical in other situations.

The clinical screening and medical care features of DPH's response include clinical screening clinics and primary care services in community centers, a dedicated inpatient unit at San Francisco General Hospital, and a highly specialized AIDS outpatient clinic. These are backed up by a comprehensive array of home support services which are discussed in Section IX. The overall purpose of these dedicated services is to concentrate the expertise of a wide variety of medical disciplines (e. g. oncology, infectious diseases, neurology, pathology, dermatology, oral medicine, virology, epidemiology, gastroenterology, parasitology, immunology, and pulmonary medicine) to provide the care required by HIV-associated diseases. The concentration minimizes the logistical complications of "moving" patients from one specialist to another and in doing so makes high quality care more accessible to them. It also makes it possible to minimize the number admissions for inpatient care and keeps the length of stay as short as possible for those admitted. Therefore, a recurring theme behind the continuum of care developed by DPH for AIDS may be stated as a slogan: "Maximize the potential of patients' maintaining themselves well at home or in residential facilities".

An equally important feature of DPH's response has been encouragement of private sector participation in the medical care of patients with HIV-associated illnesses.

B. CURRENT SERVICES

The San Francisco AIDS Foundation's AIDS Hotline is the most widely advertised source of information and referral about clinical screening and sensitive outpatient care. However, a wide range of other organizations are now sufficiently involved and knowledgeable to provide such information to people they come in contact with.

Most preliminary screening for AIDS is done by physicians in private practice, at University of California San Francisco clinics, and in community clinics. A number of epidemiologic research projects also provide screening. There are, in addition, three DPH-funded programs which offer AIDS-specific screening to low- and no-income individuals: one at the Haight Ashbury Free Medical Clinic, another at Health Center #1, and a third for pregnant women at SFGH's Women's Health Center.

The first two sites will screen approximately 320 patients during FY 86-7 and will provide referrals to appropriate care resources when indicated. The Women's Health Center will screen between 50 and 100 pregnant women this year who are at high risk for acquiring AIDS.

The AIDS Outpatient Clinic at San Francisco General Hospital (SFGH/Ward 86) specializes in care for the person with AIDS and AIDS related conditions (ARC). Clinics are organized to provide the following:

- screening and referral services for AIDS and ARC
- comprehensive medical care, including evaluation, diagnosis, treatment and follow-up care, to people with AIDS and ARC
- comprehensive and coordinated psycho-social support services for people with AIDS and ARC
- active participation in AIDS related clinical research
- various outpatient procedures that might otherwise require a hospital admission, such as transfusions, hydration, and chemotherapy administration
- on-site phlebotomy
- on-site MediCal registration and SFGH patient registration

Patient registrations at Ward 86 are expected to total 24,000 in 86-7. In October 1986, 1,700 different patients were being followed. This includes patients with AIDS-related complex as well as clinical AIDS. Of this number, approximately 80% look to Ward 86 as their primary care provider.

Mount Zion Hospital and UCSF's Moffitt Hospital have also organized dedicated outpatient clinics for the treatment of HIV-associated illnesses.

Comprehensive health maintenance and infirmity care services are currently provided to approximately 70 AIDS/ARC patients by satellite clinics of SFGH: Family Health Center, Adult Medical Center, Southeast Health Center, South of Market Health Center, and Potrero Hill Health Center. Health Centers #1 and #2 are expected to provide primary care to 450 ARC patients in 86-7, in addition to the screening services mentioned above. The Bureau of Communicable Disease Control's Division of Tuberculosis Control will provide clinical services to 30 patients with AIDS and TB in 86-7 and Jail Medical Services report that approximately 15 inmates at the county jail at any given time identify themselves or have been diagnosed as having AIDS or ARC.

SFGH's Department of Hospital Dentistry currently sees approximately 15-20 AIDS/ARC patients per month in the hospital-based Dental Unit and 25-30 in satellite units.

Fourteen hospitals in San Francisco now provide inpatient care to persons with AIDS/ARC. San Francisco General Hospital (SFGH) accounts for 33% of the total patient days. Most SFGH patients are accommodated in a 20-bed unit dedicated to the acute care of persons with AIDS/ARC (Unit 5A). When the dedicated unit is full, patients are assigned to other medical-surgical units on a space-available basis. SFGH has accommodated an average of 33 patients per day over the past four months. The centerpiece of the budget for 5A is nursing services. There are, however, an array of other subdivisions of the hospital which contribute to the care provided at 5A. They include medical

services such as radiology, anatomic pathology, surgery, gastrointestinal , psychiatry, neuropsychiatry, family practice, general medicine, medicine, endocrinology, pulmonary, neurology, and nephrology. They also include laboratory and other support services such as medical social services, physical therapy, respiratory therapy and pharmacy. There are, in addition, a number of administrative support operations which contribute as well: infection control, medical records, housekeeping, employee health services, and the medical library.

Kaiser/San Francisco, an HMO hospital which accounts for approximately 15% of inpatient care for persons with AIDS/ARC, has recently opened a 10-bed dedicated unit in the near future.

B. FACTORS INFLUENCING SERVICE CONFIGURATIONS

1. There is a steady increase in the number of people who develop clinical complications from HIV infection.

2. The population groups requiring treatment are expected to change. The preponderence of current cases of both AIDS and ARC are among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay/bisexual men. While DPH anticipates that in the next eighteen months most new cases of CDC-defined AIDS will be from the groups mentioned, we will probably see the beginning of an increase in the proportion of ARC cases who are (a) from people of color (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and (e) jail inmates. These populations may be better served in different settings.

3. The California Department of Health Services has commissioned a study of the need for special health care and psychosocial support in racial and ethnic minority communities. It is scheduled for completion by March 1988. This may have implications for planning future clinical screening and medical care in San Francisco.

4. There are new patterns in the clinical manifestations of AIDS (e. g. increase in the incidence of neurological impairment). These may require different treatment and different support services.

5. New treatments are being developed. New drugs will prolong life expectancy and therefore expand demands for health care services. New treatment regimens will create demands for different staffing, space and equipment, primarily in outpatient service settings.

6. DPH also anticipates an increase in dependence on public sector support. Patients will live longer and more will "spend down" to eligibility for greater public assistance. Some may live long enough to qualify for Medicare. Patients with certain forms of ARC often require as much care and support as patients with AIDS, yet they are not presumptively eligible for MediCal, SSI, etc., which tends to make them more dependent on local public resources.

C. POLICY REAFFIRMATION

1. DPH should maintain its general focus on comprehensive outpatient care and maximize the potential of patients' maintaining themselves well at home or in residential facilities.

2. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture and language should be evident in all service settings. The special needs of women with AIDS/ARC and dependent children should be taken into account.

3. Private providers should participate as fully as possible in the screening and care of persons with clinical manifestations of HIV infection.

4. At this point in the history of the epidemic, testing for the antibody to HIV is clinically indicated in relatively few circumstances. Any physician who accommodates the provisions of AB 403 can order the test with the informed consent of his/her patient. DPH's Microbiology Laboratory should do the necessary laboratory work free of charge for any physician who agrees to certain guidelines regarding pre- and post-test education and counseling. The sera sent to the Lab for such testing should continue to be identified by code number alone; only the physician concerned should have a record of the patient associated with the code number.

D. PROPOSED SERVICES

1. DPH should continue support of all current services at least at existing levels.

2. DPH should initiate remodeling at SFGH which will be necessary to accommodate new outpatient treatment regimens.

3. While maintaining a dedicated and comprehensivge outpatient clinic for those with AIDS and ARC at SFGH, DPH should develop the capacity of satellite programs to serve patients equally well at other sites. The satellite programs may be designed to provide primary care to more descrete population groups (e. g. women, children with AIDS/ARC, etc.) or to particular neighborhoods with a high prevelance of patients with HIV infection. Initially, DPH should expand support for clinical screening, outpatient and primary care services at Health Center #1, Health Center #2, and Southeast Health Center.

4. DPH should encourage private sector participation in clinical screening and medical care of persons with HIV-related disease by (a) providing training and technical assistance as discussed in Section VI, (b) facilitating the access of their patients to clinical trials; and (c) advocating changes in insurance and MediCal/Medicare regulations which will give an adequate return to all providers for their services to persons with AIDS/ARC.

CLINICAL SCREENING AND MEDICAL CARE

Goals	Services	Populations requiring special services	Factors influencing service development
Provision of patient care which is medically appropriate, psychosocially supportive and culturally sensitive	Information and referral	Persons with AIDS/ARC	Growing numbers of new cases and corresponding increase in numbers living
Encourage the development and use of services outside of acute care settings when clinically indicated and cost effective	Specialized screening clinics	Persons with AIDS/ARC and concurrent substance abuse problems	Anticipated shift in population groups requiring care
Encourage the development of settings in which the full range of outpatient services can be provided in a single setting	Primary care clinics	Women with AIDS/ARC	New patterns in clinical manifestations of HIV infection
	Specialized, comprehensive outpatient care	Adults with AIDS/ARC and dependent children	New treatment protocols
	Dedicated inpatient care	Adult psychiatric patients with AIDS/ARC	Increase in dependence on public sector services and MediCal
		People with AIDS/ARC who speak little no English	New information on special health care and psychosocial support needed by racial and ethnic minorities
		People in jail with AIDS/ARC	
		Hemophiliacs with AIDS/ARC	
		Children with AIDS/ARC	

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VIII. CHRONIC CARE AND RELATED SUPPORT SERVICES

A. GOAL

The general goal of San Francisco's chronic care and related support services for AIDS and ARC patients is identical to the goal of primary and acute care serivces: to provide care for patients in a manner which is medically appropriate, psycho-socially supportive and culturally sensitive, as well as cost-effective. The focus of medical care on outpatient services necessitates an extensive network of complementary services designed to maximize the potential of patients' maintaining themselves well outside of acute care settings.

B. ELEMENTS OF SERVICE

1. "Subacute care", "intermediate care" and "skilled nursing care" are variations on the theme of licensed health care in a setting that provides close 24-hour monitoring by a nursing staff when patients' conditions are relatively stable and not likely to require heroic interventions. In certain circumstances, the terms are used to identify different categories of licensure, different levels of patient acuity and staffing requirements, and different reimbursement rates. Since persons with AIDS and disabling ARC who require such care are often subject to sudden and dramatic changes in status, a high level of staff support is generally required for persons with AIDS/ARC in such settings.

2. Where HIV-related infections are concerned, home health care and in-home hospice care often go hand in hand. In some instances, for example, the care is provided to a patient recovering from an episode of pneumonia, and the care consists largely of intermittent monitoring of improvement in health status. In most instances, however, the care at home is for patients who are in the terminal phases of the disease, extremely debilitated, and focused on the dying process. Effective care under these circumstances usually requires that the patient have a viable personal support system with which the in-home hospice provider can work.

3. In-home assessments are generally conducted by public health nurses for patients who are home-bound and who may require some assistance in understanding their need for medical care or support services and in securing such services once the need is identified. In 86-7 DPH will experiment with in-home assessments by physicians and psychiatrists in certain circumstances.

4. Housing for persons with AIDS/ARC falls into three general categories: (a) short-term, emergency housing for those still in fairly good health and able to function independently while looking for more permanent arrangements; (b) long term housing for those capable of living

cooperatively with others without 24-hour staff supervision and monitoring of behavior; and (c) long term housing for people who are unlikely to manage well in a living situation which depends on cooperation with others.

5. "Practical support" is a catch-all term which encompasses a wide range of services which assist people who are very ill in activities of daily living so they can maintain themselves at home for as long as possible. It includes help with grocery shopping, laundry, cleaning, meal preparation, transportation to medical and social service appointments.

6. Emotional support for someone confronted by a life-threatening illness is particularly complex. San Francisco's response to the need for such support includes crisis intervention, psychotherapy, support groups, peer counseling for the person with AIDS/ARC and the same range of support services for members of their personal support systems.

7. Social service/entitlement program advocacy is an integral part of many organized health care services: acute care hospitals, subacute care facilities and home health care agencies all provide advocacy for their patients/clients while they are patients/clients. San Francisco also funds a "generalist" program which provides client advocacy and assistance for those not yet or not currently connected to an organized health care service.

8. Legal education, referral and advocacy is often associated with social service and entitlement programs. Where AIDS is concerned, there are special dynamics which require a more focused program: AIDS-related discrimination in employment and housing occurs in San Francisco in spite of an extensive public education program. In addition, there are special problems that arise from situations involving terminal illness, e.g. conflicts between lovers and relatives of gay men who have died from AIDS/ARC.

9. Accurate information about and referral to appropriate services is essential if the system is to work as it has been designed.

C. FACTORS INFLUENCING SERVICES

1. All of the factors mentioned in the discussion of clinical screening and other medical services apply to these services as well: the numbers are increasing; the population groups affected are expected to shift; the State has commissioned a study of the need for special health care and support services in racial and ethnic minority communities; there are new manifestations of disease and new treatment protocols; an increase in dependence on public sector support is anticipated.

2. Planning for out-of-hospital support services has been facilitated by a grant from California DHS to DPH to underwrite the costs of a study of service utilization and demand. The preliminary report for the study should be released by June 1987.

3. Subacute beds for persons with AIDS/ARC are currently quite limited. A year ago, MediCal suspended reimbursements for this level of care and reimbursements for the promised substitute level of care have not yet been authorized.

4. The California Department of Health Services has identified approximately $700,000 to be provided to a skilled nursing facility in the San Francisco area to underwrite the cost of skilled nursing care for persons with AIDS/ARC for a period of less than a year and to cover the expenses of a study of these costs and the level of care they accommodate. To date there have been no viable bids for these funds because the conditions associated with the contract do not appear to be manageable.

5. DPH has received a demonstration project grant from the US Public Health Service which provides funding to underwrite a variety of chronic care and other support services over a 27-month period beginning July 1987: intermediate care (6 beds/day), home care (5 patients/day), in-home medical assessments (physician and psychiatrist time), and residential substance abuse treatment for persons with AIDS/ARC (21 beds/day).

6. The vast majority of those who develop AIDS or severe ARC are members of behaviorial minorities (gay men and IV drug users) whose behavior is, in the minds of many, reprehensible. People with AIDS/ARC are often blamed for their condition. Patients often buy into this sense of guilt.

7. Gay men and IV drug users are minorities who often choose not to share information about their lifestyle. When AIDS or ARC is diagnosed, many are obliged to admit to family, friends and colleagues for the first time that they are members of one of these risk groups. In such situations, patients and those who comprise their personal network must often deal simultaneously with the news of a terminal illness as well as a hidden lifestyle.

8. AIDS is an infectious disease and, unlike most chronic illnesses, can be transmitted from one person to another. Even though epidemiologists are in general agreement that the virus is very difficult to transmit, many fear contagion from casual contact. Their reaction to people with AIDS/ARC often amounts to hysteria. This hysteria has created particular problems in health care and employment settings, as well as with families, friends and living situatiions.

9. AIDS is currently evident in population groups whose home support systems are (a) in some instances strong but non-traditional and therefore awkward for some to deal with, (b) in some cases weak (e. g. roommates who may not be willing or able to take on the role of primary care provider when in-home hospice services are called for), and (c) in many cases non-existent (e. g. some have never had a home support system; others have been abandoned).

10. As more adults with dependent children are diagnosed, the problem of care for the children concerned will grow.

C. CURRENT SERVICES

Garden Sullivan Hospital provides continuing hospital care for San Franciscans with AIDS and severe ARC within its ten-bed Garden Unit, which is licensed to provide acute-rehabilitation services. Common causes for placement at GSH are acute diarrhea, dementia, dehydration, and other sudden losses of function that require 24-hour care. The Unit averages 6 patients with AIDS/ARC per day; some are covered by private insurance.

Hospice of San Francisco provides a full range of home health services for persons with AIDS and severe ARC. A multidisciplinary team provides an individualized program of organized, skilled and compassionate care utilizing pain control, comfort care, and relief of the symptoms of terminal illness, whether physical, emotional, psychological or spiritual. An average daily census of 63 persons with AIDS and ARC has been contracted for in 1986-7. During the year about 403 patients will be served. Length of stay in the program averages about 57 days. Over 80% of terminations in the program are due to death, about 15% to remission, and the rest because people move.

In February 1987, Hospice of San Francisco plans to open a board and care facility (Coming Home Hospice) at which home health care will be provided residents by the AIDS home care teams described above. It is estimated that 10 of the 63 patients per day contracted for will be cared for in this environment.

Public health nurses maintain liaison with those who are AIDS care providers and will provide in-home health and social assessments of 130 AIDS/ARC patients in 86-7, followed by appropriate referrals.

The San Francisco AIDS Foundation's Emergency Housing Program provides persons with AIDS or ARC housing in a program-managed facility for up to two weeks, limited hotel accommodations for up to one week, help in obtaining public assistance and in developing alternative permanent housing resources. At this time the program is unable to serve the needs of children, people whose mobility is grossly impaired, or clients with major medical and/or psychological disorders which prohibit their utilization of independent living skills. A significant portion of the clients are chronic substance abusers and are therefore not eligible for many existing housing and support programs. The program typically houses 8 people per month (4 individuals at a time) and facilitates the placement of an average of 17 per month in hotels and through roommate referrals.

Shanti Project secures and manages low-cost, long-term housing for single men, women, and emancipated minors with AIDS (or ARC with a prognosis of six months or less) who have been displaced. Each resident is provided with a separate room; kitchen, living room, and bathrooms are shared. The aim of the program is to provide a home for persons with AIDS/ARC facing debilitation and death, not simply a shelter. The program promotes cooperative

interaction, emotional stability, and the residents' independence and control over their environment. Program staff screen prospective residents, determine eligibility, help with moving, facilitate house meetings, provide advocacy for residents needing related support services services, and generally maintain the premises. Staff do not live in or provide meals. While Shanti itself does not provide licensed home health care services, these residences are settings in which licensed home health care can be provided in a responsive and supportive environment. Volunteers from Shanti's Practical Support Program and Emotional Support Program also work with residents from a separate administrative base.

A typical Shanti residence houses four people. The program's current capacity is 41. It is estimated that 120 different individuals will be housed by this program in 1986-87. Length of stay ranges from a few weeks to more than a year, and averages 120 days. 90% of terminations are due to client deaths, 9% are at the initiative of clients, 1% are at the initiative of program staff.

Some people with AIDS or ARC have been excluded from the housing programs described above due to active substance abuse or severe psychiatric problems. Community Substance Abuse Services (CSAS) recently received funding to organize a 21-bed residential treatment program for persons with AIDS/ARC (scheduled to open July 1987) and DPH's Medically Indigent Adult Program is now working with CCSF's Department of Social Services and community based agencies on the development of a program would provide a supportive living environment for other homeless people with AIDS or ARC who are ineligible for other housing programs or residential treatment. The CSAS program is discussed further in the section on substance abuse services.

In addition to housing specifically for people with AIDS or ARC, there are several agencies providing shelter for the homeless that occasionally house people with AIDS/ARC. They include the Episcopal Sanctuary (accommodates 200 each night; primarily seniors, women and disabled), Hospitality House (shelters 80 men per night), Ozanam Reception Center (shelters 85 men per night, many of whom have substance abuse problems), the Salvation Army Shelter (accommodates 55 men per night), and San Francisco Support Services (which administrates three hotel-based programs, primarily for people with mental health problems). It is important to be clear that the numbers given above reflect total program capacity, not the numbers of persons with AIDS/ARC. the number of people with AIDS/ARC diagnoses staying in shelters for the homeless may vary greatly from one point in time to another, and their presence is not always known to shelter staff.

Shanti Project's Practical Support Volunteer Program recruits, trains and supervises volunteers to assist people with AIDS and severe ARC in the execution of their basic everyday needs: shopping, laundry, cooking. Volunteers from this program are also utilized by the Residence Program and San Francisco General Hospital Program on an as-needed basis when such support

is necessary. Currently, individual volunteers are provided to each person requesting such support. In addition, a van driver is employed to transport persons to non-emergency medical, psychiatric and social service appointments. Shanti estimates that 530 persons with AIDS/ARC and 30 significant others will benefit directly from this service in 86-7.

The Food Bank Program of the San Francisco AIDS Foundation is a community-supported program which assists indigent people with AIDS or ARC through grocery supplementation. The average income for a person with AIDS is using the Food Bank is $533 per month; the average income for a person with ARC is $301 per month plus $20 in food stamps. The Food Bank provides up to one bag per week of groceries to each client and expects to distribute 6,000 bags in 86-7

Reimbursements from the Department of Social Services for in-home supportive servies are generally handled through Hospice of San Francisco's AIDS Home Care program. There are several community-based meal delivery programs which also serve persons with AIDS/ARC.

Emotional support services are an integral part of the continuum needed to maintain people with AIDS/ARC outside of acute care settings. They are discussed in more detail in Section X (Mental Health Services) and in Section XI (Substance Abuse Services). Mental health programs include a peer counseling program managed by Shanti Project, a professional counseling and advocacy program at SFGH also managed by Shanti Project, mental health assessments and educational support groups offered by the UCSF AIDS Health Project and PMHS' Operation Concern, as well as individual and group counseling offered by Community Mental Health Services. Substance abuse contract programs administered by Community Substance Abuse Services include a variety of group and individual counseling services.

Social service/entitlement program advocacy is an integral part of many organized health care services: acute care hospitals, subacute care facilities and home health care agencies all provide advocacy for their patients/clients while they are patients/clients. DPH also funds a "generalist" program at the San Francisco AIDS Foundation which provides client advocacy and assistance for those not yet or not currently connected to an organized health care services. Services include (1) information and referral on entitlements and eligibility; (2) orientation to, scheduling and trouble shooting for General Assistance, Food Stamps, MediCal, Social Security and other entitlement programs; (3) case management of clients with multiple service needs; (4) liaison with hospitals and community agencies to reach target populations; (5) technical assistance for and training of other direct service providers; and (6) limited development of employment and other resources for clients. The staff of this program is bilingual (Spanish) and multicultural. In 86-7 this program is expected to serve 800 persons with AIDS/ARC in San Francisco.

In San Francisco there are two community organizations who provide legal education on AIDS-related issues and free or reduced-cost legal services to persons with AIDS/ARC and their significant others: the Bay Area Lawyers for Individual Freedom and National Gay Rights Advocates. Their education efforts focus on wills, testing, confidentiality, employment, insurance and housing discrimination. Their legal services address similar issues as well as probate, bankruptcy, etc. NGRA is also active in promoting legislative and administrative policy initiatives to protect and better serve people with HIV-related concerns.

The San Francisco Human Rights Commission is the administrative agency primarily responsible for the enforcement of Article 38 of the Municipal (Police) Code, the AIDS/ARC Discrimination Ordinance. Under this ordinance the Commission has conducted an public outreach campaign, and the investigation, mediation and resolution of complaints of AIDS/ARC based discrimination. In FY 85-6, the Commission investigated 65 AIDS/ARC complaints, an increase from 20 investigated complaints over the previous year. In addition to assistance to individuals, the Commission provides technical assistance to City agencies, other governmental bodies, community groups, the private sector, and the media. The Commission has played a role in the development of services for underserved populations, specifically women and ethnic minorities. As the population of people with AIDS/ARC continues to shift toward these populations, the Commission has assumed an increasingly active role in the area of housing.

Information and referral about the continuum of support services for persons with AIDS/ARC is provided to some degree by all agencies working with the epidemic. However, there is a special information and referral focus at the San Francisco AIDS Foundation and Shanti Project. The Foundation's AIDS Hotline is complemented by a special contact number which is answered exclusively by volunteers who themselves have AIDS; the information and referral functions of the Foundation's Social Service Department is discussed above. Shanti Project also handles a large number of requests for information and referral.

D. POLICY REAFFIRMATION

1. DPH should maintain its general focus on comprehensive outpatient care to maximize the potential of patients' maintaining themselves at home or in residential facilities.

2. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity, culture and language should be evident in all service configurations.

3. Service utilization assessments and cost analyses of various service configurations should be ongoing to insure that in the long run services provided are indeed the most appropriate from the perspective of both health care and cost.

4. Since Laguna Honda Hospital has a significant waiting list of persons without AIDS/ARC needing chronic care and since there are a number of private facilities in San Francisco with large numbers of unused beds, the development of San Francisco's subacute and skilled nursing care for persons with AIDS/ARC should focus initially on underutilized private facilities.

D. PROPOSED SERVICES

1. All established services in the continuum of chronic care and other support services should be maintained at least at existing levels.

2. In expanding services, priority should be given to the development of subacute/SNF services for those who cannot be effectively cared for at home.

3. In expanding services, priority should also be given to housing and specialized support services for persons with AIDS/ARC and concurrent substance abuse or other mental health problems. Funding for residential treatment for persons with AIDS/ARC has already been secured. At the same time, a joint effort with DSS should be initiated to provide long term housing for persons with AIDS/ARC (a) who cannot or will not effectively participate in residential substance abuse treatment, (b) whose clinical status has remained relatively good and does not justify subacute or skilled nursing care, and (c) whose behavior patterns require housing where staff are available 24-hours to monitor and support the cooperative living of residents. Development of these services should in the short term relieve some of the extraordinary demands currently being placed on established home care and home support programs which were not designed/intended to deal with such special problems.

4. An assessment should be undertaken of (a) persons with AIDS/ARC who do not speak English or whose personal support systems do not speak English and (b) the capacity of current service configurations to accommodate such patients/clients. In expanding services, priority should be given to addressing unmet needs revealed by the assessment.

5. An assessment should be undertaken of the special needs of pregnant women and adults with dependent children regarding housing and related support services. In expanding services, priority should be given to addressing unmet needs revealed by the assessment.

CHRONIC CARE AND RELATED SUPPORT SERVICES

Goal	Services	Populations requiring special services	Factors influencing service development
Minimize unnecessary use of acute care facilities	Subacute, intermediate and skilled nursing care	Persons with AIDS/ARC	Numbers of new cases and corresponding increase in numbers living
Maximize possibility of maintenance at home or in residential facilities	Home health and in-home hospice	Persons with AIDS/ARC and concurrent substance abuse problems	Some shift in population groups requiring care
	In-home assessments	Women with AIDS/ARC	New patterns in clinical manifestation of HIV infection
	Housing	Adults with AIDS/ARC and dependent children	New treatment protocols
	Practical support	Adult psychiatric patients with AIDS/ARC	Increase in dependence on public sector support
	Emotional support	People with AIDS/ARC who speak little or no English	No presumptive eligibility for MediCal or other entitlement program for persons with disabling ARC
	Entitlement program advocacy	People with AIDS/ARC released from jail	Factors influencing service development
	Legal education and advocacy	Hemophiliacs with AIDS/ARC	Study of current service utilization and demand will be available in June 1987
	Information and referral	Children with AIDS/ARC	Potential availability of state funding for a skilled nursing facility
			Demonstration grant funds available to underwrite startup of some chronic care and support services
			Impact of biased attitudes toward patient populations
			Psychosocial issues raised as a result of disclosure of hidden lifestyles by patients
			Fear of infection by all levels of care givers
			Non-traditional, weak or non-existent home support systems
			Care for children of adult patients

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IX. MENTAL HEALTH SERVICES

A. GOAL AND ELEMENTS OF SERVICE

A general goal of mental health services is to help clients mangage more effectively the ordinary stresses of daily living as well as cope with extraordinary pressures associated with personal and community crises. These services are, in large measure, educational.

Where AIDS is concerned, the stresses will vary depending on the individual's relationship to the epidemic. In general terms, the populations that might call on mental health services because of AIDS fall into one or more of the following categories:

(1) people who have developed clinical manifestations of advanced HIV-infection and are faced with the prospect of chronic illness or death;

(2) people who know they have been infected with HIV but remain asymptomatic and who are concerned about the prospect of developing clinical disease or transmitting the infection to others;

(3) people in groups at high risk who are concerned about being or becoming infected;

(4) people who have friends, lovers, or relatives diagnosed with or at risk for AIDS and who must share the burden and consequences of that diagnosis;

(5) people who are anticipating or grieving the death of a loved one from AIDS;

(6) people whose work brings them in contact with any of the above.

The elements of service include information and referral, crisis intervention services, individual and group psychotherapy, mental health assessments, and psychotropic medication. Because HIV infection sometimes percipitates neurological complications, assessments must be able to distinguish between such complications and other kinds of responses.

B. FACTORS INFLUENCING THE MENTAL HEALTH CARE SYSTEM

1. Most publicly subsidized crisis intervention services, as well as opportunities for individual and group therapy, are provided through Community Mental Health Services (CMHS) programs and contract services. Few programs or contractors are specifically funded to work with AIDS issues. Underfunded even before the AIDS epidemic became recognized as such, most publicly funded mental health programs have not been expanded in view of increased demands on the

mental health service delivery system related to the AIDS epidemic. They have borne whatever share of the burden they have borne by cutting back in other areas.

2. More cases of HIV-related disease are being diagnosed; more people are involved in providing care and support.

3. More people with knowledge of their HIV antibody status and attendant concerns (staying well, if positive; staying negative, if negative)

4. As was mentioned in conjunction with the discussion of primary and acute care, chronic care and related support services, the population groups requiring treatment are expected to change. The preponderence of current cases of both AIDS and ARC are among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay and bisexual men. While DPH anticipates that in the next eighteen months most new cases of CDC-defined AIDS will be from the groups mentioned, we will probably see the beginning of an increase in the proportion of ARC cases who are (a) from people of color (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and (e) jail inmates. It should be anticipated that the demand for mental health services will shift in proportion. These populations may be better served in settings other than those in which current services are provided..

5. The State DHS study of the need for special health care and psychosocial support in racial and ethnic minority communities is, as noted above, scheduled for completion by March 1988. This may have implications for planning future mental health services as well. Of particular concern will be the availability of services for those who do not speak English.

6. The results of SAMHA Center research (see Section IV) may also have implications for planning future mental health services.

7. There are instances in which mental health issues related to AIDS seem to overlap with issues being addressed by other interests of the service continuum. In particular. . .

   (a) neurological impairment associated with HIV infection are sometimes difficult to distinguish from mental health problems;

   (b) problems of mental health often coincide with those substance abuse;

   (c) while "educational support programs" often address mental health concerns, people with severe mental health problems may be particularly unresponsive or inappropriately responsive to the messages of AIDS prevention

8. While we have sometimes dealt with these mental health concerns through settings and procedures labeled "education", "substance abuse", and "medical care" (because those are the labels funding was available to support), planning efforts need to keep in mind there may be an appropriately larger role for "mental health" per se in the continuum.

9. The incidence of neurological complications among persons with AIDS and ARC is increasing.

10. The US Public Health Service's three-year demonstration project grant to DPH includes provides for psychatric outreach to home-bound AIDS/ARC patients to support the care of neurologically impaired patients in their home settings.

11. Therapists in private practice have expressed a willingness to provide therapy on a free or very low cost basis for a limited number of hours per week for people with AIDS/ARC and others with AIDS-related concerns. The PHS grant mentioned above provides the UCSF AIDS Health Project with a half time staff member to (a) recruit and coordinate these volunteer services, (b) facilitate the development of a support system for them (e. g. regular inservice training opportunities), and (c) screen and refer prospective clients as appropriate.

C. CURRENT SERVICES

The UCSF AIDS Health Project (AHP) currently provides a range of mental health services on Ward 86, the AIDS outpatient clinic at San Francisco General Hospital. The AHP worker has an established consultative role within the clinic and functions as a member of the treatment team. Clients are seen as a result of either self- or staff-generated referral for assessment and evaluation because of acute psychological or emotional distress, behavioral disturbance, or interest in the group work (for stress reduction, women with AIDS, or couples) offered by AHP. These groups are geared toward helping individuals deal more effectively with this disease. Thus, the services offered in this setting are: crisis intervention, psychiatric assessments, patient-centered consultation with medical staff and personnel, group interventions, short-term psychotherapy services (not to exceed 12 weekly sessions for no more than six clients at any time), and referral to other resources. Approximately 600 clients are expected to benefit from these services in 86-7.

The Emotional Support Program of Shanti Project trains community volunteers to provide free counseling services to people with AIDS/severe ARC and their significant others, and both their biological and extended families. Currently, individual counselors are provided to each person requesting such support and services are provided for as long as the client and counselor feel it is useful. Group counseling is available for those who prefer group support. Shanti estimates that 850 people with AIDS/ARC and 800 others will be served in 86-7.

Shanti Project also provides professional counselors to meet the psychosocial needs of patients and their visitors on Unit 5A. These counselors are available to AIDS patients, visitors and hospital staff in other areas of the hospital as well as on an as-needed basis. They provide crisis counseling in situations such as death, a patient's removal from life-support systems, potential suicide, worsening of patient's condition necessitating transfer to a Critical Care Unit, etc. They also provide patient advocacy services to optimize patient input regarding care and management. On Ward 86 a Shanti counselor is available for 26 hours per week for the newly diagnosed person with AIDS and their loved ones to provide emotional support services similar to those offered by the Shanti Unit 5A staff as well as liaison to other Shanti services. In 86-7 Shanti clients on 5A are expected to number 750; those on Ward 86, 440.

Shanti Project's support for individuals who are grieving is described above. As an extension of its in-home hospice services, Hospice of San Francisco also provides bereavement counseling to the survivors of patients served at home.

Publicly-funded mental health services outside of SFGH are concentrated in the Adult Outpatient Programs of Community Mental Health Services (CMHS). The services provided range from crisis intervention to individual or group therapy consisting of one or two weekly sessions. Clients with AIDS or severe ARC are seen in longer-term treatment up to and beyond a year, with no specific time limits set. Those with less severe ARC are transitioned to non-psychiatric support groups after stabilization. Direct clinical services are also provided to persons who are in acute distress secondary to HIV antibody testing or who would be considered among the "worried well". These are seen for immediate brief treatment, then referred back to non-psychiatric supports. In a typical month CMHS programs see 60 persons with AIDS or ARC and 25 persons in acute distress secondary to HIV antibody testing.

D. POLICY REAFFIRMATION

1. DPH should maintain mental health support services to maximize the potential of patients' maintaining themselves at home or in residential facilities. This includes direct care to persons with AIDS and ARC as well as to significant others whose participation in providing care at home is essential to its success.

2. DPH should insure that mental health services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity culture and language should be evident in all service settings.

3. Private providers should be encouraged to participate as fully as possible in the provision of mental health services related to AIDS with clinical manifestations of HIV infection.

D. PROPOSED SERVICES

1. DPH should continue support of all current services at least at existing levels.

2. Any expansion of CMHS programs and contract services related to AIDS should parallel the development of satellite programs for primary care and specialized outpatient clinics. In other words a satellite program designed to provide primary care to more discrete population groups (e. g. women, children with AIDS/ARC, etc.) or to particular neighborhoods with a high prevelance of HIV infection should be complemented with an expansion of mental health services to the same population and its support systems.

Readers should note that services related to research and provider education as they pertain to mental health services are discussed in Sections IV and VI respectively.

MENTAL HEALTH SERVICES

Goals	Services	Populations requiring special services	Factors influencing service development
Utilize mental health services to support AIDS prevention among those at risk	Information and referral	Persons with AIDS/ARC	Numbers developing clinical disease growing
Address the extraordinary pressures associated with the epidemic on the community's mental health	Crisis intervention	Persons who are neurologically impaired as a result of HIV infection	Numbers indicating neurological complications growing
	Mental health assessments including those which identify neurological complications associated with HIV infection	Asymptomatic seropositives	Numbers with knowledge of HIV antibody status growing
		Other worried well	Shift in population groups requiring care
	Group and individual psychotherapy	Bereaved	Increase in dependence on public sector support
	Psychotropic medication	Care providers	Current mental health services are underfunded and full
			New information about psychosocial support needs of racial and ethnic minority communities
			Overlap with other program areas
			Potential larger role for mental health services
			New psychiatric evaluation services planned for homebound
			Free therapy services by volunteer therapists in private practice

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X. SUBSTANCE ABUSE SERVICES

A. GOALS:

The relationship of AIDS and substance abuse is exceptionally intimate and complex. Substance abusers are at particularly high risk for exposure to or transmission of HIV as a consequence of (a) sharing contaminated needles or (b) engaging in unsafe sexual activity when disinhibited by substance use. Once infected, the progress to clinical disease is accelerated by a health status already compromised by substance use. Their treatment is often complicated and the availability of personal and community support services also limited by their substance abuse.

As far as AIDS prevention is concerned, the goals of DPH's program may be best described as incremental and pragmatic. The initial goal is to end the sharing of contaminated needles and the unsafe sexual activity associated with substance use. The larger goal is to end the substance use which encourages needle sharing and unsafe sexual activity. Where providing health care to persons with AIDS/ARC and a concurrent substance abuse problem at issue, the initial goal is to end substance use which undermines attempts to stem or reverse the progress of the disease. Since the prognosis for anyone with AIDS is quite grim, in many cases the joint goal of AIDS care and substance abuse services shifts at some point to controlling the substance abuse sufficiently to insure that the balance of the individual's life is lived with as much dignity and comfort as possible without compromising the well-being of others.

B. FACTORS INFLUENCING SUBSTANCE ABUSE SERVICES

1. The State funding used to initiate many of these AIDS-specific programs in San Francisco is expected to run out on March 31, 1986. Renewal of AIDS/substance abuse demonstration project funding was not covered by Administration in the 86-7 State budget and legislative action to put funds into the budget was vetoed by the governor. Maintenance of the existing levels of service is an immediate issue.

2. Given the circumstances under which HIV is communicable, all elements of substance abuse prevention, detoxification and treatment services are ipso facto AIDS prevention services. By extension,, all shortcomings of existing substance abuse services are shortcomings in AIDS prevention services. The only circumstances under which AIDS prevention education among substance abusers is not also substance abuse intervention are when the focus of the education is limited to particular patterns of substance use (e. g. needle sharing or getting high before sex) and does not encompass the substance use itself.

3. Established substance abuse treatment programs typically focus on the future benefits of a clean and substance-free lifestyle. Even methadone maintenance programs, which begin by substituting one substance use for another, are promoted as stepping stones to a drug-free lifestyle. For someone with AIDS/ARC, prospects of a future are often very limited. The paradox is not lost on patients

4. Many of the assumptions about what PWAs/ARC want and need which underlie most of the services on the current health care/support services continuum are not valid if substance abuse is a factor. For example, a home health care/in-home hospice program which assumes that each client/ patient has a personal support system that can be galvanized and constructively integrated into the home health care plan does not work well in situations where the personal support system is nonexistent or not particularly responsible. The behavior of substance abusers is often characterized as non-compliant, anti-social and self-destructive. This characterization does not match the premises on which many current services are built.

5. Substance abuse compromises further an already-compromised immune system, tends to accelerate the progress of clinical disease, and often precludes certain treatment protocols. The resulting drain on acute care resources is intensified.

6. Ninety-two percent of AIDS cases reported in San Francisco with a history of IV drug use are gay/bisexual men; 90.5% of these are White, 6.5% Black, 2.7% Latino, and 0.3% Asian/Pacific Islander. Of the 21 heterosexual men with a history of IV drug use, more than half (12) are Black and one fifth (4) are Latino. To date nine women in San Francisco with a history of IV drug use have been diagnosed with AIDS.

7. Seroconversion rates among women and men (gay/bisexual men, men who have sex with other men but do not consider themselves to be gay/bisexual, and heterosexual men) who abuse substances (particularly those who share needles) are higher than among gay/bisexual men who are not substance abusers. Consequently the incidence of AIDS/ARC among all substance abusers is expected in the long run to rise at a faster rate than among gay/bisexual men who are not substance abusers. This will be reflected directly or indirectly in increases in the proportion of cases who are women and indirectly in the proportion who are children.

8. The results of SAMHA Center research (see Section IV) may have implications for planning future AIDS prevention/substance abuse services.

C. CURRENT SERVICES

It has been argued above that all 16,000 clients of Community Substance Abuse Services as well as the particpants in voluntary community support services such as Alcoholics Anonymous are involved in AIDS prevention programs. Stopping the spread of AIDS cannot be contemplated without an appreciation of this argument. The programs singled out in the following paragraphs have received funding labeled "AIDS-specific", but they constitute only a fraction of the overall effort and potential of San Francisco's continuum of services.

Methadone maintenance and related counseling are provided by three programs to approximately 35 persons who have AIDS/ARC or who are seropositive are provided: UCSF's Substance Abuse Services at San Francisco General Hospital's Ward 92, Bayview/Hunter's Point Foundation, and Westside Community Mental Health Center. Clients receive a daily dose of methadone and are seen weekly or more often by a counselor. UCSF Substance Abuse Services, a hospital-based program, deals with medically more complicated cases. UCSF's AIDS Health Project (AHP) has staff based at Ward 92 who provide assessment and consultation services to AIDS/ARC patients at Unit 5A and Ward 86 who indicate substance abuse problems. Consultations regarding 1,650 clients are anticipated by AHP during 86-7.

The Alcohol Evaluation and Treatment Center (AETC) at San Francisco General Hospital provides residential detoxification services to limited numbers of substance abusers with AIDS/ARC.

Bay Area Addiction Research and Treatment (BAART) and the California Detoxification Program (CDP) have provided counseling and followup care to 22 patients who are seropositive or diagnosed with AIDS/ARC and their significant others.

The Multicultural Prevention Resource Center, Asian-American Residential Services and Horizons Unlimited (Projecto Ayuda) cooperate in providing AIDS prevention education to a variety of programs serving people of color.

Seven outreach workers provide outreach education and health promotion to IV drug users and social services providers in the Tenderloin, Polk Street, South of Market, the Haight, and the Mission districts.under the aegis of the Midcity Consortium to Combat AIDS (MCtCA). Many of those contacted are adolescent runaways. This outreach includes, for example, distributing comic strips which illustrate the most effective methods for decontaminating hypodermic syringes and distributing one-ounce bottles of household bleach. The MCtCA expects to provide 2,400 formal and informal counseling sessions, 8,000 safe sex and safe needle-using practice education contacts, 960 agency referrals, and 120 poster presentations during the fiscal year.

18th Street Services is an outpatient substance abuse counseling center for gay men in San Francisco which provides (1) all clients with comprehensive education about their risk for AIDS and what they can do about it and (2) substance abuse treatment for men with AIDS and ARC. Services include community education as well as individual, group and couples counseling to address these concerns. The goal of the program is to empower clients to participate actively and positively in mainstream society, to achieve higher self-esteem and to find satisfaction in their lives while remaining clean and sober. Clients are required to abstain from drug and alcohol use while in counseling, and it is strongly suggested that they utilize 12-step programs. The agency is currently treating over 90 active clients, of whom approximately 80% are HIV positive or have AIDS or ARC.

PMHS' Operation Concern/Operation Recovery provides individual and group counseling to gay IV stimulant users who are diagnosed with AIDS/ARC or who test antibody positive. Their partners and significant others are also encouraged to participate in counseling as co-dependents in order to assist clients providing a supportive system for their recovery from IV stimulant substance abuse and adoption of safe sexual practices. Approximately 90 clients will be served in the course of the fiscal year.

The Drug Detoxification, Rehabilitation, and Aftercare Project of the Haight Ashbury Free Medical Clinic provides outpatient detoxification treatment services to San Francisco residents with drug abuse problems. These services are designed around a 21-day detoxification period, during which withdrawal symptoms are ameliorated by a carefully prescribed regimen of medications; this is followed by a "drug free" aftercare period of unlimited duration. Supportive, one-on-one counseling is the principal intervention during both the detoxification and aftercare phases. All persons are examined by a physician at admission, and treatment is given for chronic or acute medical problems. Group and family counseling is also available, as is vocational rehabilitation counseling. All entering clients are provided with brochures, comic strips, and other written materials relevant to AIDS risk reduction. AIDS-related posters are placed prominently around the Detox facility. During the most recent year, 2,200 different individuals were treated, with an average of just less than ten treatment sessions each. Of these persons, about 65% were primary abusers of heroin, 13% of cocaine, 10% of methamphetamine, 3% of opiates other than heroin, and 9% of other drugs. Nearly 90% of these clients had a recent history of needle use, and about 90% of that group admitted to recent sharing of needles.

By July 1987, Community Substance Abuse Services will contract for a residential treatment program specifically for substance abusers with AIDS/ARC. The program will provide the following under one roof: (a) basic 24-hour staffing appropriate to a substance abuse treatment program; (b) treatment for a range of substance abuse (including amphetamines, opiates, and alcohol); (c) rules which call for abstinence but which identify sanctions other than a long exile from the program if this rule is broken; (d) on-site detoxification to insure program continuity and a "short loop" back into the program if needed; (e) access to AIDS-specific outpatient care when needed; (f) rooms and bathroom facilities which make home health care for those who are very sick feasible; (g) AIDS-specific home care on an as-needed basis. A capacity of 21 beds has been targeted. Residents entering the terminal stage of AIDS will in most cases be transferred to a subacute care facility.

The University of California San Francisco's Substance Abuse and Mental Health in AIDS (SAMHA) Center is supported by a grant from the National Institute of Mental Health (NIMH) and the National Institute of Drug Abuse (NIDA). It creates a working environment in which academic researchers at UCSF and UCB, county health officials at DPH, and minority health professionals at Bayview Hunter's Point Foundation can benefit from a pooling of knowledge, skills and community activities. The focus of the center is on

developing and testing preventive interventions and on formulating and disseminating health policy guidelines. Investigations specific to AIDS and substance abuse include studies of (a) the impact of residential treatment on AIDS prevention, (b) the impact of methadone maintenance on sexual behavior and needle use, and (c) the impact of HIV antibody testing and notification on IV drug users.

D. POLICY REAFFIRMATION

1. DPH recognizes that all current substance abuse services are in some measure AIDS prevention programs. The "AIDS agenda" should be a specific item in all program descriptions developed for FY 1987-88.

2. DPH recognizes that preventing the transmission of AIDS may require extraordinary measures, such as educating IV drug users about how to decontaminate their syringes, which may create paradoxes for programs whose goals include stopping substance abuse.

3. DPH recognizes that substance abusers with AIDS/ARC present special problems for providers of health care and other support services. Support services specific to the needs of substance abusers should be developed and maintained.

3. DPH should insure that substance abuse services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture and language should be evident in all service settings.

E. PROPOSED SERVICES

1. DPH should maintain the types of service currently in place.

2. In expanding services, first priority should be given to the elimination of waiting lists of all existing treatment programs (detoxification, residential and outpatient counseling services).

3. In expanding services, second priority should be given to prescription substitution, such as methadone maintenance slots for all heroin addicts accepting this form of drug treatment.

4. In expanding services, third priority should be given to outreach to uninfected at risk substance using populations through street based preventive intervention and referral and through demonstrations of materials and tools through rap groups and community meetings for populations at risk.

5. In expanding services first priority should be given to community education about substance abuse and the risk for AIDS associated with it.

Readers should note that services related to research and provider education as they pertain to substance abuse services are discussed in Sections IV and VI respectively.

AIDS/SUBSTANCE ABUSE SERVICES

Goals	Services	Populations requiring special services	Factors influencing service development
End the sharing of contaminated needles and unsafe sexual activity associated with substance use	Outpatient and inpatient detoxification	IV drug users	Continuance of current programs at issue due to lack of State funding
End the substance use which encourages needle sharing and unsafe sexual activity	Outpatient and inpatient treatment and rehabilitation	People whose sexual behavior is disinhibited by substance abuse	Substance abuse prevention services are considered AIDS prevention services
End substance use which undermines attempts to stem or reverse the progress of the disease	Recruitment to treatment programs	PWAs/ARC with concurrent substance abuse problems who are able to participate in substance abuse treatment	The potential limited life span of someone with AIDS/ARC is a disincentive to changing substance abuse patterns
Control the substance abuse sufficiently to insure highest possible quality of remaining life without compromising well-being of others	Prevention education to substance abusers not in treatment	PWAs/ARC with concurrent substance abuse problems who are not able to participate in substance abuse treatment	Care of PWA/ARC presents a new set of problems for service providers
	AIDS health care and support services specifically designed to accommodate needs of persons who are also substance abusers		Compound problems of clinical disease and substance abuse
			Seroconversion rate in this population growing

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XII. ADMINISTRATIVE SUPPORT AND COORDINATION

A. GOALS

The goal of the administrative services supporting AIDS programs in San Francisco is to insure that the community's response to the epidemic is equal to the task and cost-effectively managed. These services are also concerned that the financial burden of meeting the demands of the epidemic are distributed reasonably between the public and private sector and, within the pubic sector, distributed fairly among local, state, and national resources.

B. ORGANIZATIONAL STRUCTURE AND DIVISION OF RESPONSIBILITIES

Except where noted, all of the publically funded services described in this document are provided directly by the Department of Public Health or by community-based contractors of the Department.

The Department is governed by a seven-member Health Commission appointed by the Mayor for staggered four-year terms. The Director of Health is the chief administrative officer of the Department appointed by the Commission.

Under the Director of Health, there are four major subdivisions of the Department, each of which provides AIDS-related services. Community Public Health Programs includes (a) Health Centers involved in anonymous antibody testing, clinical screening, and primary care for persons with ARC; (b) the Bureau of Family Health, which provides liaison to the San Francsico Unified School District's AIDS education efforts as well as managing pregnancy testing, prenatal and perinatal clinics at the Health Centers; and (c) the Bureau of Communicable Disease Control, which manages the City's sexually transmitted disease clinic and tuberculosis clinic, in addition to serving as liaison to community blood banks and providing some contact tracing/recipient education.

Community Mental Health Programs is the umbrella for Community Mental Health Services, Community Substance Abuse Services and Forensic Services.

San Francisco General Hospital is the County's general acute care facility. SFGH's specialized AIDS services include a dedicated inpatient unit (5A) and comprehensive outpatient services at Ward 86. People with AIDS/ARC are also seen by SFGH-based dental services and a variety of satellite clinics. Laguna Honda Hospital is the County's long term care facility. The vast majority of patients are elderly. Laguna Honda Hospital's provision of services to AIDs patients has been limited to date.

As a special arm of his office, the Director has established and recently reorganized the AIDS Office. This Office assists him generally with the coordination and integration of departmental and contract services provided by the Department for AIDS. The Office is also responsible for AIDS surveillance and DPH's participation in epidemiologic studies, as well as the administration of specific grants involving inter-divisional cooperation and a variety of contracts for education programs, chronic care and related support services.

The Office of Planning and Program Support provides the Director with general assistance in planning and liaison to the California legislature and San Francisco's congressional delegation in Washington, D. C.

C. ADVISORY GROUPS

There are a number of groups who contribute in one way or another to the Department's policies and planning for AIDS services. The concerns of some are general, some specific to a particular subdivision of the Department, others have developed in response to community-based concerns. Some are more active than others; some have been active in the past and have become inactive. The most active include the following:

1. The Mayor's AIDS Task Force:

   Dr. Werdegar and other senior staff of DPH, Dr. Sande and UCSF's AIDS specialists at SFGH, Commissioners Lee and Foster, and others. Their main function has been to keep the Mayor aprised of emerging epidemiological trends, diagnosis and treatment issues, and prevention strategies.

2. The Director's AIDS Medical Advisory Group:

   Physicians from DPH, SFGH, UCSF, the San Francisco Medical Society, Bay Area Physicians for Human Rights, and others from private practice. Their main function has been to help keep the Director's communication lines to the medical community open.

3. The Departmental AIDS Committee:

   Representatives of all the major subdivisions of DPH providing AIDS-related services. Their main function is to advise the Director on the development of departmental AIDS policy and program, coordination of programs between subdivisions of the department, and discussion of program strategy.

4. The Director's AIDS Advisory Committee:

   Convened initially as the AIDS Health Care Services Advisory Committee and chaired by the Director of Health, this committee includes members from AIDS contract services agencies, subdivisions of DPH providing AIDS services, private sector providers (e. g physicians in private practice, Kaiser-Permanente HMO) and community interest groups (e. g. people with AIDS/ARC, ethnic minority groups, gay-identified organizations). The group replaces the AIDS Coordinating Committee and advises the Director of Health on the development and coordination of AIDS programs for which the Department is responsible. It was recently expanded to provide greater representation from racial/ethnic minorities and community groups; its scope was also broadened to include education as well as health care services.

5. The Advisory Committee on AIDS Services in Ethnic Minority Communities:

   The Director of Health convened this group to provide a direct avenue of input from San Francisco's ethnic minority communities regarding their concerns about AIDS. There is substantial overlap between this group's membership and that of the AIDS Advisory Committee.

There are also several population-specific task forces organized by DPH. These include the AIDS Substance Abuse Task Force, the AIDS Forensics Task Force, and the Perinatal and Pediatric AIDS Advisory Committee

The San Francisco Unified School District AIDS Task Force focuses on the development of AIDS education guidelines and curriculum for school-age youth and teacher training. The AIDS Research Council is composed of representatives of both DPH and UCSF. Its function is information sharing, coordination, and identification of funding for AIDS research.

Community-based organizations or individuals have convened coalitions, committees and task forces whose principal concerns are the impact of AIDS on their respective constituencies. They include The Latino Coalition for AIDS/SIDA Education and Action, The Black Coalition on AIDS, The Third World AIDS Advisory Task Force, The Women's AIDS Network, The Tenderloin AIDS Network, The Homeless Service Providers Coalition AIDS Subcommittee, The California Prostitutes' Education Project, People with AIDS/San Francisco, The AIDS/ARC Vigil, Mobilization Against AIDS, and the California Hemophilia Association.

The Kaiser Community Council on AIDS Health Care, initiated by the administration of Kaiser Permanente Medical Center in 1985, includes representatives from Kaiser and designated community agencies. Its function is to facilitate the provision of health care for Kaiser Health Plan members who are persons with AIDS/ARC, through cooperation and coordination with community AIDS service providers.

There are, additionally, professional associations with an interests in AIDS with which DPH personnel have contact: the San Francisco Medical Society, Bay Area Physicians for Human Rights, and Bay Area Lawyers for Individual Freedom.

D. FACTORS WHICH HAVE A SPECIAL IMPACT ON ADMINISTRATIVE SUPPORT SERVICES, BUDGETING, ETC.

1. The rapid and ongoing expansion of demand for services discussed above provides enormous pressure all by itself.

2. In the early period of the epidemic, the climate in which local providers operated was cooperative. As the epidemic progresses and vested interests in various "pieces of the action" are refined, a shift to more open competition for scarce resources seems inevitable.

3. Because AIDS has such a direct and visible impact on so many features of public health and health care, AIDS is sometimes "blamed" for shortcomings in services which existed before AIDS began to take its toll.

4. With one exception in the case of State funding, State and Federal support for AIDS-related services in San Francisco has been in the form of contracts/cooperative agreements issued after a competitive application process. It is clear that DPH has been at a disadvantage in many instances in which we have used local funding to initiate services prior to the availability of State/Federal funding for them. Since the RFPs often preclude using State or Federal grants to underwrite activities for which local funding has already been allocated and since DPH has initiated such a comprehensive range of activities with local funding, our applications are often limited to proposals to round out an already functioning operation. We will continue to operate with this handicap except when (a) block grants are provided, (b) local matching funds are required, or (c) we delay initiating particular types of services until State or Federal funding is available.

5. State and Federal grant and cooperative agreement funding is frequently provided on fiscal cycles that do not coincide with DPH's fiscal year.

6. Contracts with the State Department of Health Service are a particularly heavy administrative burden for DPH: contract terms are very narrowly defined and inflexible; contract processing typically requires more than five months (up to nine in some instances) after the initial proposal has been approved; DHS staff are frequently obliged to renege on verbal commitments made in contract negotiations; prospects of contract renewal are usually quite unclear. Cooperative agreements with the Centers for Disease Control and the Health Resources and Services Administration are, in contrast, reasonably flexible and quickly processed.

7. State Department of Health Services is increasingly inclined to bypass local departments of health when contracting for local services. In the past six months there have been three instances in which DHS elected to contract directly with (a) community-based organizations for AIDS prevention education, (b) community-based organizations for a study of health care needs specific to people of color, and (c) skilled nursing facilities.

8. DPH's own contracting procedures have become much more complex in light of (a) Health Commission review of all contracts and (b) MBE/WBE/LBE interests. Civil Service review of all intentions to contract has been part of the process from the beginning, but it nonetheless contributes to the administrative complexity of contract management.

9. Filling grant-funded positions is an enormously complex and time-consuming administrative process. Where State-funding is involved (with 5-9 month delays in processing contract documents) the problems are magnified.

10. There are two areas of bureaucratic turf in the City/County of San Francisco that are particularly difficult to negotiate in the midst of a rapidly expanding epidemic: (1) the requirements for bringing new personnel on board and (2) the restrictions on the acquisition and deployment of computer hardware.

11. Beginning in FY 1986-87, there has been a general understanding at DPH that new and expanded AIDS services should depend as little as possible on ad valorem funding. This is not an anti-AIDS position. It simply reflects the reality that other needed services have been neglected in order to make funding available for AIDS, and the pinch is being felt everywhere.

12. Until recently San Francisco has been able to manage services for PWAs/ARC regardless of the limitations on State/Federal funding and programs and private insurance. San Francisco is reaching its limit, thus making us increasingly dependent on these other financing systems. For the first time in San Francisco there is a shortage of those services not otherwise reimbursed: most notably for the chronic care components of the system. The epidemic now requires that other finance systems change their policies to permit the development of these badly needed services. If there is no change in this regard, the burden on the acute care system will simply outstrip these resources.

13. The wide variety of interest groups that have emerged in conjunction with the epidemic demand that their various interests be appreciated and addressed in plans for AIDS services. An adequate "hearing" for these interests and the development and implementation of programs require lead time and staff support which is not currently available to the AIDS Office.

E. POLICY REAFFIRMATION

1. The Department of Public Health reaffirms its commitment to insuring that San Francisco's response to the AIDS epidemic is equal to the task and cost-effectively managed.

2. DPH also reaffirms that the financial burden of meeting the demands of the epidemic should be distributed reasonably between the public and private sector and, within the pubic sector, distributed fairly among local, state, and national resources.

3. DPH recognizes that the interests of community advocacy groups and community based organizations must be appreciated and addressed in plans for AIDS services.

4. DPH maintains that, in situations where the local department of health has an established and credible track record in AIDS prevention and health care services, State and Federal agencies should be encouraged to support these services through block grants to the local department. Competitive application procedures in these situations create an administrative burden on all parties that does not serve the epidemic well. Guidelines for block grant use may well confine the use of block grant funds to certain areas of endeavor (e. g. prevention education or out-of-hospital support services which MediCal does not subsidize) and may well set some expectations about the utilization of appropriate community-based organizations (e. g. "the services supported by this grant must reflect a substantial level of cooperation with and involvement of appropriate community-based organizations")

5. In situations where there are opportunities for direct funding of community-based organizations, the funding agency involved should encourage close cooperation with related programs in the continuum.

6. DPH expects that the California Department of Health Services streamline its contract procedures to (a) provide much faster processing of contracts and (b) give contractors more flexibility to respond quickly and constructively to emerging needs in the area of service for which the funds are earmarked. DPH recognizes that the greater utilization of block grants mentioned above would accomplish this goal as well.

7. DPH requests that State and Federal funding be offered local jurisdictions in a manner which encourages joint utilization of State/Federal and local dollars. State and Federal funding restrictions which arbitrarily penalize local jurisdictions who have taken the initiative to respond to needs created by the epidemic, simply because they have taken the initiative, should be withdrawn.

8. DPH encourages the City and County of San Francisco to recognize that an epidemic is in progress and it is necessary to waive personnel classification, testing, and requisition processing requirements that contribute to delays of more than two months in filling critical positions. CCSF should also waive requirements that all computer equipment (even equipment which is leased or purchased with grant funds) be part of a plan developed long before needs raised by the epidemic could possibly be anticipated.

D. PROPOSED SERVICES

1. Current coordination and administrative support services should be maintained.

2. The AIDS Office should be expanded immediately to include a Medical Director to supervise epidemiologic research, planning for chronic care services, and to assist with the oversight of subacute and home care contract services and an Associate Medical Director with special responsibilities for racial/ethnic minority programs and maternal and child health services.

3. As planning and administrative responsibilities of the AIDS Office are expanded, staff support for these responsibilities should expand.

ADMINISTRATIVE SUPPORT AND COORDINATION

Goals	Features	Participants	Factors influencing program development
Insure that planning and management of responses to the epidemic are appropriate, coordinated, and responsive to local dynamics	Ad valorem budget development and management	Mayor/Board of Supervisors	General pressure of an epidemic growing in size and complexity
Distribute the financial burden of the epidemic reasonably among private and public sector; in public sector, distribute fairly among local, state and national sources	Departmental services	Health Commission	Emergence of special interest groups, potential for competition
	Grant applications	DPH-Central Office	Perception that AIDS expenditures cause reductions in other health programs
	Contract service management	DPH-Community Health Programs	Most State/Federal support through a competitive allocation process and favors situations in which no services have been developed with local funding
	Advocacy for State/Federal funding support	DPH-Community Mental Health Programs	State and Federal grants on fiscal cycles different from DPH
	Advocacy for State/Federal policy support	DPH-SFGH	Contracting with State DHS is particularly difficult
		DPH-PPS	State DHS inclined to bypass local departments in contracting for local services
		DPH-Contract services	Local contract processing and personnel recruitment procedure very complex
		DPH-Accounting	Development of new or expanded programs will depend on new state and federal funding and changes in insurance reimbursement policies
		DPH-Personnel	Additional staff needed to respond to emerging demands of community interest groups and to insure effective program planning and implementation
		Private hospitals	
		Other private sector providers	
		UCSF	
		Advisory groups	
		Advocacy groups	

APPENDICES

AIDS in San Francisco: A Status Report
and Preliminary Plan for FY 1987-88

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: CASES REPORTED THROUGH NOVEMBER 30, 1986.

TOTAL CASES: Cases N = 2,654 Living N = 1,177

	No. of cases	Percent	No. living	Percent
IVDU	368	13.9	161	13.7
Non-IVDU	2,286	86.1	1,016	86.3
White	2,291	86.3	1,009	85.7
Black	150	5.7	62	5.3
Latino	177	6.7	86	7.3
Asian	34	1.3	19	1.6
Other	2	-1	1	0
Gay/bisexual	2,572	96.9	1,146	97.4
Non-gay/bisexual	82	3.1	31	2.6
Male	2,629	99.1	1,166	99.1
Female	25	.9	11	.9
0 - 4 years of age	6	.2	2	.2
5 - 19 years of age	5	.2	1	.1
20 - 49 years of age	2,386	89.9	1,084	92.1
50 - Over	257	9.7	90	7.6

IVDU SUBTOTAL: Cases N = 368

	Male		Female	
	Gay	Non-Gay	Gay	Non-Gay
White	306	5	0	6
Black	22	12	0	1
Latino	9	4	0	0
Asian	1	0	0	2
Other	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: CASES REPORTED THROUGH NOVEMBER 30, 1986.

WHITE SUBTOTAL: Cases N = 2,291 Living N = 1,009

	No. of cases	Percent	No. living	Percent
IVDU	317	13.8	146	14.5
Non-IVDU	1,974	76.7	863	85.5
Gay/bisexual	2,253	98.3	995	98.6
Non-gay/bisexual	38	1.7	14	1.4
Male	2,277	99.4	1,003	99.4
Female	14	.6	6	.6
0 - 4 years of age	2	.1	1	.1
5 - 19 years of age	2	.1	0	.0
20 - 49 years of age	2,063	90.0	932	92.4
50 - Over		224	9.8	76
7.5				

BLACK SUBTOTAL: Cases N = 150 Living N = 62

	No. of cases	Percent	No.	
living	Percent			
IVDU	35	23.3	8	12.9
Non-IVDU	115	76.7	54	87.1
Gay/bisexual	121	80.7	52	83.9
Non-gay/bisexual	29	19.3	10	16.1
Male	142	94.7	59	95.2
Female	8	5.3	3	4.8
0 - 4 years of age	3	2.0	1	1.6
5 - 19 years of age	1	.7	0	0
20 - 49 years of age	133	88.7	57	91.9
50 - Over	13	8.7	4	6.5

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: CASES REPORTED THROUGH NOVEMBER 30, 1986.

LATINO SUBTOTAL:	Cases N = 177		Living N = 86	
	No. of cases	Percent	No. living	Percent
IVDU	13	7.3	5	5.8
Non-IVDU	164	92.7	81	94.2
Gay/bisexual	167	94.4	81	94.2
Non-gay/bisexual	10	5.6	5	5.8
Male	176	99.4	85	98.8
Female	1	.6	1	1.2
0 - 4 years of age	1	.6	0	0
5 - 19 years of age	2	1.1	1	1.2
20 - 49 years of age	157	88.7	76	88.4
50 - Over	17	9.6	9	10.5

ASIAN SUBTOTAL:	Cases N = 34		Living N = 19	
	No. of cases	Percent	No. living	Percent
IVDU	3	8.8	2	10.5
Non-IVDU	31	91.2	17	89.5
Gay/bisexual	29	85.3	17	89.5
Non-gay/bisexual	5	14.7	2	10.5
Male	32	94.1	18	94.7
Female	2	5.9	1	5.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	31	91.2	18	94.7
50 - Over	3	8.8	1	5.3

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: CASES REPORTED THROUGH NOVEMBER 30, 1986.

OTHER SUBTOTAL:	Cases N =		Living N =	1
	No. of cases	Percent	No. living	Percent
IVDU	0	0	0	0
Non-IVDU	2	100	1	100
Gay/bisexual	2	100	1	100
Non-gay/bisexual	0	0	0	0
Male	2	100	1	100
Female	0	0	0	0
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	2	100	1	100
50 - Over	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: PROJECTIONS TO JUNE 30, 1987

TOTAL CASES: Cases N = 3,297 Living N = 1,226

	No. of cases	Percent	No. living	Percent
IVDU	452	13.7	164	13.4
Non-IVDU	2,845	86.3	1,062	86.6
White	2,822	85.6	1,050	85.6
Black	207	6.3	77	6.3
Latino	219	6.6	81	6.6
Asian	46	1.4	17	1.4
Other	3	0.1	1	0.1
Gay/bisexual	3,191	96.8	1,190	97.1
Non-gay/bisexual	106	3.2	36	2.9
Male	3,264	99.0	1,212	98.9
Female	33	1.0	14	1.1
0 - 4 years of age	7	.2	2	.2
5 - 19 years of age	6	.2	1	.1
20 - 49 years of age	2,964	89.9	1,127	91.9
50 - Over	320	9.7	96	7.8

IVDU SUBTOTAL: Cases N = 452

	Male		Female	
	Gay	Non-Gay	Gay	Non-Gay
White	372	7	0	8
Black	29	15	0	1
Latino	9	5	0	0
Asian	1	0	0	3
Other	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: PROJECTIONS TO JUNE 30, 1987

PROJECTIONS TO JUNE 30, 1987

WHITE SUBTOTAL: Cases N = 2,822 Living N = 1,050

	No. of cases	Percent	No. living	Percent
IVDU	381	13.5	144	13.7
Non-IVDU	2,441	86.5	906	86.3
Gay/bisexual	2,774	98.3	1,036	98.7
Non-gay/bisexual	48	1.7	14	1.3
Male	2,802	99.3	1,043	99.3
Female	20	.7	7	.7
0 - 4 years of age	3	.1	1	.1
5 - 19 years of age	3	.1	0	0
20 - 49 years of age	2,540	90.0	968	92.2
50 - Over	276	9.8	81	7.7

BLACK SUBTOTAL: Cases N = 207 Living N = 77

	No. of cases	Percent	No. living	Percent
IVDU	50	24.1	14	18.6
Non-IVDU	157	75.9	63	81.4
Gay/bisexual	165	79.6	64	83.1
Non-gay/bisexual	42	20.4	13	16.9
Male	195	94.2	72	93.2
Female	12	5.8	5	6.8
0 - 4 years of age	5	2.2	1	1.7
5 - 19 years of age	1	.7	0	0
20 - 49 years of age	181	87.6	71	91.5
50 - Over	20	9.5	5	6.8

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: PROJECTIONS TO JUNE 30, 1987

LATINO SUBTOTAL:	Cases N = 219		Living N = 81	
	No. of cases	Percent	No. living	Percent
IVDU	16	7.1	5	6.6
Non-IVDU	203	92.9	76	93.4
Gay/bisexual	208	94.8	76	93.4
Non-gay/bisexual	11	5.2	5	6.6
Male	218	99.4	80	98.7
Female	1	.6	1	1.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	1	.6	0	0
20 - 49 years of age	198	90.3	74	90.8
50 - Over	20	9.0	7	9.2

ASIAN SUBTOTAL:	Cases N = 46		Living N = 17	
	No. of cases	Percent	No. living	Percent
IVDU	5	10	2	10.5
Non-IVDU	41	90	15	89.5
Gay/bisexual	38	83.3	14	84.2
Non-gay/bisexual	8	16.7	3	15.8
Male	43	93.3	16	94.7
Female	3	6.7	1	5.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	41	90	15	89.5
50 - Over	5	10	2	10.5

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: PROJECTIONS TO JUNE 30, 1988

TOTAL CASES: Cases N = 4,485 Living N = 1,449

	No. of cases	Percent	No. living	Percent
IVDU	614	13.7	194	13.4
Non-IVDU	3,871	86.3	1,255	86.6
White	3,826	85.3	1,236	85.3
Black	291	6.5	94	6.5
Latino	296	6.6	96	6.6
Asian	67	1.5	22	1.5
Other	5	0.1	1	0.1
Gay/bisexual	4,341	96.8	1,407	97.1
Non-gay/bisexual	144	3.2	42	2.9
Male	4,440	99.0	1,433	98.9
Female	45	1.0	16	1.1
0 - 4 years of age	9	.2	3	.2
5 - 19 years of age	9	.2	0	0
20 - 49 years of age	4,032	89.9	1,333	92.0
50 - Over	435	9.7	113	7.8

IVDU SUBTOTAL: Cases N = 614

	Male		Female	
	Gay	Non-Gay	Gay	Non-Gay
White	505	9	0	11
Black	39	21	0	2
Latino	13	7	0	0
Asian	1	0	0	4
Other	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: PROJECTIONS TO JUNE 30, 1988

WHITE SUBTOTAL: Cases N = 3,826 Living N = 1,236

	No. of cases	Percent	No. living	Percent
IVDU	516	13.5	169	13.7
Non-IVDU	3,310	86.5	1,067	86.3
Gay/bisexual	3,761	98.3	1,220	98.7
Non-gay/bisexual	65	1.7	16	1.3
Male	3,799	99.3	1,227	99.3
Female	27	.7	9	.7
0 - 4 years of age	4	.1	1	.1
5 - 19 years of age	4	.1	0	0
20 - 49 years of age	3,443	90.0	1,140	92.2
50 - Over	375	9.8	95	7.7

BLACK SUBTOTAL: Cases N = 291 Living N = 94

	No. of cases	Percent	No. living	Percent
IVDU	70	24.1	17	18.6
Non-IVDU	221	75.9	77	81.4
Gay/bisexual	232	79.6	78	83.1
Non-gay/bisexual	59	20.4	16	16.9
Male	274	94.2	88	93.2
Female	17	5.8	6	6.8
0 - 4 years of age	6	2.2	2	1.7
5 - 19 years of age	2	.7	0	0
20 - 49 years of age	255	87.6	86	91.5
50 - Over	28	9.5	6	6.8

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO 1981-86: PROJECTIONS TO JUNE 30, 1988

LATINO SUBTOTAL:	Cases N = 296		Living N = 96	
	No. of cases	Percent	No. living	Percent
IVDU	21	7.1	6	6.6
Non-IVDU	275	92.9	90	93.4
Gay/bisexual	281	94.8	90	93.4
Non-gay/bisexual	15	5.2	6	6.6
Male	294	99.4	95	98.7
Female	2	.6	1	1.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	2	.6	0	0
20 - 49 years of age	267	90.3	87	90.8
50 - Over	27	9.0	9	9.2

ASIAN SUBTOTAL:	Cases N = 67		Living N = 22	
	No. of cases	Percent	No. living	Percent
IVDU	7	10	2	10.5
Non-IVDU	60	90	20	89.5
Gay/bisexual	56	83.3	19	84.2
Non-gay/bisexual	11	16.7	3	15.8
Male	62	93.3	21	94.7
Female	5	6.7	1	5.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	60	90	20	89.5
50 - Over	7	10	2	10.5

APPENDIX B List of individuals/organizations invited to submit written descriptions of services provided and needed August/September 1986.

Jim Geary, Exec. Director
Shanti Project
890 Hayes
San Francisco, CA 94117

Tim Wolfred, Exec. Director
SF AIDS Foundation
333 Valencia, 4th Floor
San Francisco, CA 94103

Jim Dilley, MD
AIDS Health Project
333 Valencia, 4th Floor
San Francisco, CA 94103

William R. Vitiello, PhD
AIDS Prevention Coordinator
Operation Concern
1853 Market Street
San Francisco, CA 94103

Bill Folk, Proj. Admin.
Stop AIDS Project, Inc.
4111 - 18th Street, Ste. 4
San Francisco, CA 94114

George Dykstra, Director
Haight-Ashbury Free Med.Clinic
558 Clayton Street
San Francisco, CA 94117

Pat Foy, RN,
Director of Nursing
Garden Sullivan Hospital
Pacific Medical Center
PO Box 7999
San Francisco, CA 94120

Jeannee Martin, RN, Director
Hospice of San Francisco
225 - 30th Street
San Francisco, CA 94131

Amanda Houston-Hamilton, Chair
Black Coalition on AIDS *
726 Broderick St.
San Francisco, CA 94117

Yolanda Ranquillo, Project Director
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FORMAT FOR INFORMATION TO BE INCLUDED IN DPH REPORT
ON AIDS SERVICES IN SAN FRANCISCO
8/29/86

A. Submissions will fall into one of four categories:

1. A description of CURRENT SERVICES for which no expansion will be needed in 1987-8.

2. A description of CURRENT SERVICES accompanied by a proposal to EXPAND CURRENT SERVICES between now and June 1988.

3. A description of a NEEDED SERVICE for which no provider exists. The "current services" section of this submission will consist simply of the observation that the service configuration does not currently exist or that it exists but not for the population targeted.

4. A description of a CURRENT SERVICE which the provider proposes to reduce or eliminate in favor of a different service configuration.

B. Each submission should be limited to no more than two pages, preferably one, and should consist of information about what services are currently offered by the provider, what related expansions or new services are needed, if any, and how much each costs.

C. PROVIDERS WHO OFFER MULTIPLE SERVICES (AND THEREFORE HAVE MULTIPLE UNITS OF SERVICE) SHOULD DEVELOP ONE SUBMISSION FOR EACH "COST CENTER".

D. Each submission should should include succinct answers to the following questions regarding CURRENT SERVICES, if appropriate:

1. Services provided - What needs are being addressed and how?

2. Population served - Whose needs are being addressed?

3. Elements of service - How are units of service defined? How many units are currently being provided? How many different individuals are currently being served (if unit is other than the number being served)? Be sure the numbers given relate to the fiscal cycle identified in D/5.

4. Staffing - List paid staff positions providing services with FTE information.

5. Funding - What is the current budget for these services? GIVE THE TOTAL FROM EACH DISTINCT SOURCE AND SPECIFY THE FISCAL CYCLE. Some who are providing services with funding from State or Federal grants will have a fiscal cycle that does not coincide with the City/County's.

E. Each submission should include succinct answers to the following questions regarding EXPANDED OR NEW SERVICES, if any.

1. Services to be provided - What needs will be addressed and how?

2. Population to be served - Whose needs will be addressed?

3. Method of assessment - How were these needs determined?

4. Elements of service - How are units of service to be defined? How many units will be provided? How many different individuals will be served (if unit is other than the number being served)? Be sure the numbers given relate to the fiscal cycle defined in D/6.

5 New staff needed - List paid staff positions with FTE and salary information.

6. New funding needed/anticipated - List major budget categories of your organization's standard budget and give total for each. Salaries total should agree with staffing configuration described in E/5.

It is expected that most proposals for expanded or new services will be built around a 12-month budget (with grant applications and planning for 1987-88 in mind). However, in certain circumstances, (such as the one included in the illustration, in which funding from one source is available now if it can be matched by funding from another), budgets for the balance of 1986-7 may be submitted. If the budget given covers any functions for less than a 12 month period, indicate the necessary increase in the "base", if any, if the service were extended for a full year.

Attached is a sample that has been developed for purposes of illustration only. It is not an actual submission from Shanti Project.

jwa

SAMPLE* SUBMISSION TO DPH REPORT ON AIDS

Service category: Housing

Provider: Shanti Project

Date of submission: September 9, 1986

CURRENT SERVICES

Current services: Shanti Project secures and manages low cost, long term housing for persons with AIDS and severe ARC who have been displaced. Each resident is provided with a separate room; kitchen, living room, and bathrooms are shared. The aim of the program is to provide a home for persons with AIDS/ARC facing debilitation and death, not simply a shelter. The program promotes cooperative interaction, emotional stability, and the residents' independence and control over their environment.

Program staff screen prospective residents, determine eligibility, help with moving, facilitate house meetings, provide advocacy for residents needing other support services, and generally maintain the premises. Staff do not live in or provide meals. While Shanti itself does not provide licensed home health care services, these residences are settings in which licensed home health care can be provided in a responsive and supportive environment. Volunteers from Shanti's Practical Support Program and Emotional Support Program also work with residents from a separate administrative base.

Population served: Single men, women and emancipated minors with AIDS or severe ARC are accommodated; lovers/spouses and dependent children are not. Since the success of this program depends on residents being able to interact cooperatively and provide mutual support without frequent staff interventions or close monitoring of house rules, active substance abusers are either turned down upon application or turned out if found using substances while in residence. Those who are currently receiving outpating treatment for a substance abuse problem are admitted to the program as long as they remain clean and sober.

Elements of service: A typical unit houses four. The program's current capacity is 40. It is estimated that 120 different individuals will be provided 14,400 resident days by this program in 1986-7. Length of stay ranges from a few weeks to more than a year, and averages 120 days. 76% of terminations are due to client deaths, 19% are at the initiative of clients, and 5% are at the initiative of program staff.

Staffing:

TOTAL: 7.20 FTEs	
Residence Director	1.00
Residence advocates	1.50
Maintenance/sanitation	3.00
Office support	1.65
Clinical consultant	.05

* Not an actual Shanti submission. To illustrate format only.

Funding:

City/ad valorem	452,163
State through City	-0-
Private donations	27,351
Client rent (25% of income) (All June-July cycles)	55,000
TOTAL:	$ 534,514

PROPOSED EXPANSION

Services to be provided: Shanti proposes to open two additional houses to accommodate residents as described above.

Population to be served: As described above.

Method of assessment: Waiting list of eligible prospective clients has ranged between 15 and 27 at any time over past six months and the overall number of people at any given time living with AIDS/severe ARC continues to grow. Establishment of an intermediate care facility (6 beds) and a residential treatment program for substance abusers with AIDS/ARC (13 beds), both scheduled to open by 7/87, will relieve some of this demand. They will also slow the turnover in Shanti residences, however, since PWAs/severe ARC whose immediate needs include special care as well as housing will in some instances be placed in one of the new alternatives.

Elements of service:. Two additional units would bring overall capacity to 48 residents. With support identified by 11/1/86, the new units could be ready for occupancy by 1/1/87 and would provide an additional 730 resident days in 86-7, 1,460 per year thereafter.

New staff needed:

Resident Advocate -
$2,083/mo./FTE x 30% x 7 mo. only in 86-7
Maintenance Specialist -
$1,650/mo./FTE x 50% x 7 mo. only in 86-7

New funding needed/anticipated:

	Bal. of 86-7		Annualized	
	Needed	Anticipated*	Needed	Anticipated*
Personnel	$ 10,149	-0-	17,399	-0-
Benefits	1,522	-0-	2,610	-0-
Rent:				
8 rms x $375/mo.	-0-	21,000	-0-	36,000
Maintenance:				
$2,000 start-up/house	4,000	-0-	-0-	-0-
$144/mo. ongoing/house	-0-	2,016	-0-	3,456
Utilities and insurance:	-0-	2,009	-0-	3,444
Shanti indirects (8%)	1,254	2,002	1,601	3,432
TOTALS	$ 16,925	27,027	21,610	46,332

*$115 per rm/month expected from clients; balance pledged by private sources.

APPENDIX D - AIDS ADVISORY COMMITTEE
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APPENDIX E:. Memo describing recent investments in AIDS-related services to IV drug users, jail inmates, women at risk through heterosexual contact, youth, and people of color

Date: October 28, 1986

To: David Werdegar, MD

From: Jeff Amory

Re: New investments in AIDS-related services to IV drug users, jail inmates, women at risk through heterosexual contact, youth, and racial/ethnic minority groups.

There has been much discussion in recent months about the development and expansion of AIDS services to risk groups in San Francisco. The following review of activities and developments over the past nine months may be useful background for your discussions with community representatives.

The population groups included in this review are not mutually exclusive groups. Groups A and B include males and females, youth and adults, people of all ethnic and racial backgrounds, heterosexuals, gay-identified males, and males who have sex with other males but do not regard themselves as gay or homosexual. Groups C, D and E overlap with A and B, as well as each other.

A. Intravenous drug abusers who are at risk because they share needles and other substance abusers who are at risk because they engage in high-risk sexual practices while "disinhibited" by whatever substance is used. With both groups, if AIDS or ARC develops, health care is complicated by their substance use.

B. Jail/detention facility inmates at risk from needle sharing and unprotected intercourse that occur in detention facilities, and, often, as members of high risk groups outside the jail.

C. Women who are sexual partners of men who are in high risk groups. Their risk is to themselves as well as to any child that is conceived from the relationship, and to other partners.

D. Youth who are sexually active and/or using substances and lack education about AIDS.

E. Members of racial and ethnic minority groups whose access to education programs has been limited.

I will limit my observations to efforts whose outcomes have been recorded since January 1986. The report will also be limited to activities associated with AIDS-specific public funding.

A. NEW AIDS RELATED SERVICES SPECIFIC TO SUBSTANCE ABUSERS

1. In early 1985 DPH's AIDS Activity Office (AAO), working in cooperation with DPH's Community Substance Abuse Services (CSAS) and Assemblyman Agnos' staff, identified IV drug users as a population requiring special interventions with regard to AIDS. The following observations were central to our discussions with Agnos's staff and others on this issue:

   (a) The principal short term goal of the a prevention program has to be reducing/eliminating the sharing of needles. While enabling all abusers to become clean and sober remains a long term concern, it is recognized that needle-sharing per se must be the first target.

   (b) AIDS prevention education among IV drug users is not likely to have long term impact unless substance abuse treatment is immediately available to support significant behavioral changes.

   (c) Most existing services to people with clinical AIDS are designed for people who desire and can benefit from cooperative living and cost effective outpatient and in-home support services. People with AIDS/ARC and a concurrent substance abuse problem (whether IV or otherwise) do not function well in these programs. A specific effort is needed to deal with the AIDS/ARC and substance abuse problem at the same time.

   Funding for special support services for substance abusers at risk for AIDS and with AIDS/ARC in San Francisco was proposed by Assemblyman Agnos for the State's 85-6 budget. The Governor vetoed the Legislature's initial appropriation but eventually signed a $400,000 demonstration project appropriation authorized through SB1251. DPH then had to enter into prolonged negotiations with California DHS to get the funds channeled to San Francisco services. By March 1986, DPH had secured the $400,000 for the following Departmental and contract services:

Amount	Service
$ 52,011	AETC at SFGH provides residential detox services to substance abusers with AIDS/ARC.
100,000	Bayview Hunter's Point Foundation provides short term methadone maintenance (6 months) at two sites (Bayview and Westside) and AIDS prevention information through subcontracts with three programs (Asian-American Residential Services, Multicultural Prevention Resource Center, and Horizons Unlimited.)
36,000	UCSF/Department of Psychiatry Substance Abuse Services provides short term methadone maintenance at SFGH to medically more complicated cases.
101,000	18th Street Services provides counseling and education to gay IV stimulant users.
20,000	PMC/Operation Concern provides referral, education and counseling to gay IV stimulant users.
57,000	Youth Projects Inc., acting as the fiscal agent for MidCity Consortium to Combat AIDS (Youth Environment Study, Haight Ashbury Free Medical Clinic, Real Alternatives Program, Central City Hospitality House, Larkin Street Youth Center), provides educational outreach to substance users out of treatment, particularly youth. (Note: This level of funding to Youth Projects was for six months of operations. All other SB1251-supported substance abuse services were underwritten for twelve months.)
33,989	DPH's Community Substance Abuse Services (CSAS).
$400,000	Subtotal from SB1251 to AIDS/substance abuse services

2. In March 1986 DPH's AIDS Activity Office, in response to an RFP issued by the Centers for Disease Control (CDC), applied for funding for a comprehensive AIDS prevention/education program, part of which was to be built around confidential antibody testing in substance abuse treatment settings. The request for such a program had been made by DPH's CSAS in response to input offered by CSAS service poviders. The application was approved by CDC but was sufficiently low on the priority list of

approved applications that funding was not forthcoming. In July 1986 another CDC RFP was issued and a revised version of the earlier proposal was submitted. A scaled down version of this proposal was funded by CDC. The contract with CDC is to support provider-based antibody testing programs in substance abuse treatment settings starting in early 1987. Costs associated with laboratory services, the development of educational materials to be used on site, and administrative overhead ---which will also support parallel services at pregnancy testing, prenatal and perinatal clinics---are prorated below:

Amount	Service
$ 21,393	Pretest education, blood drawing and posttest education and counseling at Bayview Hunters Point Foundation (8 months).
21,393	The same at Westside Community Mental Health Center (8 months).
18,720	The same at Haight-Ashbury Free Medical Clinic (7 months).
18,720	The same at BAART/Geary (7 months).
18,720	The same at BAART/Townsend (7 months).
15,051	The same at SFGH/Ward 93 (9 months).
19,997	Laboratory support for the above.
28,851	Educational materials development and provider training.
11,679	General administration and CCSF indirects.
$ 174,524	Subtotal to AIDS/substance abuse services

3. In June 1986 two complementary proposals were developed by the AAO for health care service demonstration projects. One was submitted to the Robert Wood Johnson Foundation (RWJF), the other to the US Public Health Service (PHS). The PHS application earmarked 71% of the total available for direct services in San Francisco for a residential treatment program for substance abusers with AIDS/ARC. The application to RWJF was turned down and, at PHS' request, the elements of the RWJF application were incorporated into a revised proposal to PHS. The revised and subsequently approved PHS budget earmarks 43% of the total available for direct service in San Francisco for a 21-bed residential treatment program for substance abusers with AIDS/ARC.

Amount	Service
$ 1,121,511	A 21-bed residential substance abuse treatment program for persons with AIDS/ARC. The facility will include on-premises detox services. The contractor will be determined after an RFP is issued by DPH's CSAS. Services are expected to begin in July 1987. The budget covers a 27-month period.

4. In April 1986 DPH responded to an RFP from the California Department of Health Services for an "AIDS Education Augmentation Project" with an application which included a request to expand the outreach effort to substance abusers out of treatment and to extend its period of operations beyond the six-month period originally covered (see Item A/1 above). The application was approved but was placed sufficiently low on the priority list that it was not funded. In September 1986 DPH included in a block grant request to DHS a proposal to assign $57,000 to keep this effort alive at least through the end of the fiscal period for which all other State-support AIDS/substance abuse programs were funded. We have received telephone approval of this proposal.

Amount	Service
$ 57,000	Extension of Youth Project Inc. contract to provide educational outreach to substance abusers out of treatment, particularly street youth, to the twelve-month cycle provided other contractors with SB1251 funding.
$ 1,753,035	TOTAL

In sum, between January and October 1986, $1,753,035 of new resources available to the Department have been committed to AIDS education, prevention support, and health care services to substance abusers with AIDS or at risk for AIDS.

It is worth noting that NIMH recently approved a proposal to establish a SUBSTANCE ABUSE AND MENTAL HEALTH IN AIDS CENTER in San Francisco. The budget provides more than $2.5 million over a five year period. DPH cooperated with UCSF in the development of the proposal. The Center's focus will be on developing and testing preventive interventions; DPH-subsidized service programs will benefit directly from these interventions.

B. NEW AIDS RELATED SERVICES SPECIFIC TO JAIL INMATES

1. In March 1986, the AAO applied to the Centers for Disease Control for funding to be assigned DPH's Division of Forensic Services to design and implement AIDS education interventions in the eight jails and detention facilities in San Francisco. The application was approved and funding effective mid-April.

Amount	Service
$ 105,021	Rotating poster displays, distribution of AIDS materials during the booking process, regular AIDS education for inmates at all sites, and regular AIDS orientation training for all new staff.

C. NEW AIDS-RELATED SERVICES SPECIFIC TO WOMEN

In March 1986 the AAO applied to CDC for funding for a comprehensive AIDS prevention education program, part of which was to be built around confidential antibody testing in pregnancy testing, prenatal and perinatal clinics. The application was approved by CDC but not funded. In July 1986 another RFP was issued---this one specific to antibody testing---and a revised version of the earlier proposal was submitted. A scaled down version of the proposal has been funded by CDC. The contract with CDC provides that the following distribution of funds will be forthcoming to the Bureau of Family Health to support these services. Costs associated with laboratory services, the development of educational materials to be used on site, and administrative overhead---which will also support parallel services at substance abuse treatment settings---are prorated below.

Amount	Service
$ 35,492	Pretest education, blood drawing and posttest education and counseling at Health Center 2 (9 months).
35,491	The same at Health Center 3 (9 months).
18,533	Laboratory support for the above.
26,741	Educational materials development and provider training.
10,825	General administration and CCSF indirects.
127,082	Total new AIDS-related services specific to women

D. NEW AIDS-RELATED SERVICES SPECIFIC TO YOUTH

1. New outreach to street youth is discussed in the section on services to substance abusers. Budgets totalling $114,000 are accounted for under that heading (see A/1 and A/4).

2. In March 1986 the AAO included in an application to CDC a proposal for DPH's Bureau of Family Health to collaborate with the San Francisco Unified School District on the development and piloting of an AIDS curriculum for middle school and high school students. The proposal was approved and funding became effective mid-April 1986.

Amount	Service
$ 74,885	Developing an AIDS awareness and prevention education curriculum for San Francisco Public Schools, training SFUSD teachers to use the curriculum, and piloting its use in the classroom.

3. The proposals to the Centers for Disease Control discussed above included provisions for providing confidential antibody testing through San Francisco's City Clinic program for sexually transmitted diseases. Although this is not exclusively a program for youth, many of City Clinic's clients are youth. As with the discussion of funding for parallel services in substance abuse settings and women's clinics, costs associated with laboratory servbices, the development of educational materials to be used on site, and administrative overhead have been prorated in the budget summary below:

Amount	Service
$ 15,041	Pretest education, blood drawing and posttest education and counseling at City Clinic (9 months).
10,242	Laboratory support for the above.
14,477	Educational materials development and provider training.
5,982	General administration and CCSF indirects.
46,042	CTS subtotal to AIDS-related services for youth

In sum, between January and October 1986, $234,927 of new resources available to the Department have been committed to AIDS education and prevention support programs exclusively or primarily for youth. This includes $114,000 in funds which "overlap" with the discussion of substance abuse services above

E. NEW AIDS-RELATED SERVICES TO SPECIFIC RACIAL/ETHNIC MINORITIES

1. In May 1986 in its application to DHS for renewal of an 86-7 contract for AIDS information and education, the AAO requested that $134,400 of the $666,640 renewal expected be applied to two studies ($67,200 each) of high risk subgroups of San Francisco's Black and Latino communities. In each case the research team membership was to reflect substantial representation from the community being studied. Although DHS had, in 1985-6, approved a budget of $53,962 for a population -based baseline survey of at-risk heterosexuals (sexually active with multiple partners) and a budget of $40,000 for a population based followup survey of gay and bisexual men, DHS insisted on capping the two studies proposed for 1986-7 (which all consulted agreed would be more complex and difficult) at $25,000 each. The difference between the $50,000 offered by DHS and the $134,400 requested by the AAO was assigned by DHS to other counties to forestall any further discussion of the issue.

   In subsequent contract negotiations, the AAO proposed to reinstate the two studies at the $134,400 level even within the reduced overall grant total offered by DHS. DHS staff initially agreed to this counterproposal and then withdrew their approval.

   In August 1986, the AAO repeated the $134,400 request to DHS, with an expanded explanation and justification, in an application for an augmentation grant. The request was again denied.

   In September 1986, the AAO proposed to combine $75,000 from a block grant for AIDS prevention from DHS (but the use of which DHS has less arbitrary control over than is the case with other grants) with the $50,000 left in the I&E grant renewal to make a $125,000 package for the two studies ($62,500 each). In October, DHS indicated approval of this arrangement, although their approval has not been provided in writing.

Amount	Service
$125,000	Contractor(s), to be determined after reviewing responses to a competitive RFP, will conduct qualitative studies (focus groups) preliminary to a population based survey of at-risk groups within the two communities as well as the baseline surveys themselves. A sampling of approximately 400 is expected to participate in the survey in each community. It is anticipated that this size sample of at risk individuals will entail at least 8,000 initial contacts in the general community concerned. It is DPH's intent that the results of these new surveys be comparable to those conducted for gay-identified/bisexual men and for heterosexuals at risk, with emphasis on applicability to development and evaluation of educational intervention programs.

2. In August 1986, the AAO applied to the California Department of Health Services for $314,400 for studies (see E/1 above) and outreach education services through community-based contractors in the Black, Latino, and Asian communities of San Francisco. The application was approved in part by DHS but sufficiently low on the priority list* that funding was not forthcoming. In the same round of DHS activity, two community-based organizations in San Francisco were funded by DHS directly to provide AIDS education to their respective communities. THE TWO PROGRAMS LISTED BELOW ARE THEREFORE PUBLICALLY FUNDED BUT THEY ARE NOT FUNDED THROUGH OR COORDINATED BY DPH.

Amount	Service
$150,000	Bayview Hunters Point Foundation
130,000	Instituto Familiar de la Raza

3. In September 1986 block grant proposal to DHS, the AAO requested a half time physician to serve as medical concultant to San Francisco AIDS education efforts. Funding for this position had been requested in other proposals submitted to DHS in May and August but these requests had been turned down. The September request, however, has received telephone approval. This physician will have a special responsibility for liaison to operations serving racial and ethnic minority communities.

Amount	Service
$ 31,353	Physician consultant to the AIDS activity office on AIDS education and liaison to services which focus on racial and ethnic minority communities.

In sum, between January and October 1986, $436,353 of new resources available to San Francisco programs have been committed to AIDS education and prevention support services specifically targeted to racial and ethnic minority communities.

It is worth noting that the Third World Component of the Substance Abuse and Mental Health in AIDS (SAMHA) Center introduced in Section A above will include two major projects: (1) AIDS prevention through community action networks for Blacks and Latinos and (2) an epidemiologic review of AIDS in ethnic minority communities. Of the $2.5 million grant total, $500,000 is budgeted for these projects.

* It was at the top of the list of approved proposals which remained after funds appropriated were all assigned.

F. SUMMARY

The discussion above accounts for more than $5 million in new resources secured in the past nine months being targeted to programs and support services specific to the risk groups identified. This is funding over and above the proportions of already-established program budgets which serve the populations concerned to some degree but whose service is not routinely defined as specific to these risk groups. Forty five percent of the total is funding that is managed by the San Francisco Department of Public Health.

$ 1,753,035	to AIDS education, prevention support and health care services to substance abusers with AIDS or at risk for AIDS; $114,000 of this amount is specific to street youth
105,021	for AIDS prevention education for jail detainees and training of jail staff
127,082	for AIDS education and support specific to pregnant women or women contemplating pregnancy
120,927	for AIDS education and prevention support specific to youth
436,352	for AIDS education and prevention support specific to racial and ethnic minority communities
2,500,000	for a Substance Abuse and Mental Health in AIDS Center; $500,000 of this amount is specific to racial and ethnic minority communities.
$ 5,042,417	Total